Bradford Teaching Hospitals NHS Foundation Trust

Evidence appendix

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This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.

Facts and data about this trust

Bradford teaching hospitals became an NHS foundation trust in April 2004. It is responsible for providing hospital services for the people of Bradford and communities across Yorkshire. It serves a core population of around 530,000 people and provides specialist services for around 1.2 million people in the region. Specialist services include;

- Neonatal care
- Urology
- Vascular services
- Renal care
- Cancer care
- Cochlear implants
- Cardiology

Annually there are around 6000 babies born, over 140,000 attendances in A &E, 120,000 in-patients who receive care, and 500,000 outpatients' appointments. There are around 300,000 surgical operations each year. There are around 780 in-patient beds.

Almost 5,800 staff work over several sites at the trust. The sites include Bradford Royal Infirmary, which provides most inpatient services, and St Luke's hospital, which predominantly provides outpatient and rehabilitation services. The trust has local community hospitals at Westwood Park, Westbourne Green, Shipley and Eccleshill. There are around 500 volunteers at the trust who support the care of patients and visitors.

In early 2017, a new £28 million wing opened at Bradford Royal Infirmary, part of a £75 million investment to improve patient care. A £2 million refurbishment of the accident and emergency department was also completed in 2017.

The trust is a teaching hospital, with strong links to local universities. The Bradford Institute for Health Research (BIHR) was established in 2007 by the trust. Since then the BIHR has developed and increased its expertise in clinical research and applied health research to support better patient outcomes and improved healthcare throughout the Bradford community. In 2018 over 41,000 people were recruited to research studies, and there were over 650 active research studies in 2018/2019.

Services provided at the trust are commissioned by four main commissioners;

- NHS Bradford City CCG
- NHS Bradford Districts CCG
- NHS Airedale, Wharfedale and Craven CCG
- NHS England Specialist Commissioning.

The trust is a member of the West Yorkshire association of acute trusts (WYAAT) which worked to develop and deliver collaborative solutions to some regional health challenges.

Acute hospital sites at the trust

A list of the acute hospitals at Bradford Teaching Hospitals NHS Foundation Trust is shown below:

Name of hospital site	Address	Details of any specialist services provided at the site
Bradford Royal Infirmary	Duckworth Lane, Bradford BD9 6RJ	Acute services, diagnostics and outpatient services. Emergency department providing 24 hour, seven days a week, comprehensive accident and emergency service including resuscitation and high dependency unit, ambulatory care unit, dedicated paediatric service and a primary care streaming service.
St Luke's Hospital	Little Horton Lane, Bradford BD5 0NA	Paediatric outpatients, dermatology outpatients, HIV service, intermediate care hub, neuro physiology, occupational physiology, physiotherapy, children's community nursing renal unit, adults outpatients, dietetics, orthotics, orthodontics, pain management, psychology, pre-assessment and dental surgery.
Shipley Hospital	98 Kirkgate, Shipley BD18 3LT	Physiotherapy, colorectal, and GP Direct Access X-ray services. This is an outreach location providing the opportunity to deliver 'care closer to home' from this locality. The facility provides capacity for outpatient consultation, follow up review, diagnostic testing and treatment. It is consultant led and supported by a multi-disciplinary team.
Eccleshill Community Hospital	450 Harrogate Road, Eccleshill, Bradford, West Yorkshire, BD10 0JE	Diagnostic and outpatient services. Day surgery

Westbourne Green community hospital	26 Heaton Road, Bradford, West Yorkshire BD8 8RA	Outpatients Intermediate care ward
Westwood Park Diagnostic and Treatment Centre	Swift Drive, off Cooper Lane. BD6 3NL	Medical care Diagnostic and outpatient services Intermediate care ward

(Source: Trust Website / Routine Provider Information Request (RPIR) – Sites tab)

Is this organisation well-led?

Leadership

As part of our inspection, to rate the organisation for how well led it was, we interviewed the members of the board, both the executive and non-executive directors, and a broad range of senior staff across the trust. This included a wide group of clinical and non-clinical service and speciality leaders. We met and spoke with a wide range of front-line staff to ask their views on the leadership and governance of the trust. We looked at a range of performance and quality reports, audits and action plans; board meeting minutes, and papers to the board, investigations, and feedback from patients, local people and stakeholders.

The trust board had the appropriate range of capability, skills, knowledge and experience to perform its role. The board of directors' portfolios covered all key areas. The trust was led by a board of directors who were responsible for all aspects of the operation and performance of the trust, and for its effective governance. This included setting the corporate strategy and organisational culture, taking those decisions reserved for the board, and being accountable to stakeholders for those decisions.

The board was a unitary board, which meant all members of the board had collective responsibility for decisions made. Non-executive directors and executive directors shared the same degree of accountability. Senior leaders demonstrated an understanding of most priorities and challenges facing the trust. They spoke with insight about key risks around workforce, maintaining operational performance and financial pressures. These challenges were described in the clinical service strategy and were recognised in the corporate risk register and board assurance framework.

There had been several senior leadership changes at the trust in the last two years. After the previous chief executive left in April 2019, the director of strategy and information took on the role as acting chief executive.

The board was led by the chairperson who commenced in post in May 2019. The trust was led by the chief executive who commenced in post in November 2019. There had been an acting chief operating officer who was appointed in January 2018 and became the substantive post holder in April 2018.

Non-executive positions on the board were;

- The chairperson
- Eight non-executive directors (NEDs), including two who were recently appointed in November 2019.

Executive director positions on the board were;

- The chief executive
- The chief nurse
- The chief medical officer
- The chief operating office (and deputy chief executive)
- The director of strategy and integration
- The director of finance
- The director of human resources
- The chief digital and information officer

Board Members

We saw there was a good gender balance of board members and just less than a quarter of all board members were from a Black, Asian and Minority Ethnic (BAME) background.

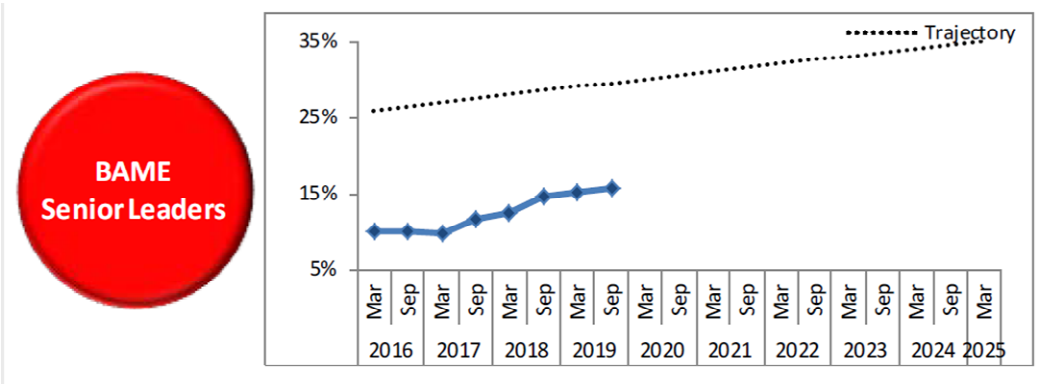
There were no BAME executive board members at the trust and 57% were female.

Of the non-executive board members 43% were BAME and 43% were female.

Staff group	BME %	Female %
Executive directors	0%	57%
Non-executive directors	43%	43%
All board members	21%	50%

(Source: Routine Provider Information Request (RPIR) – Board Diversity tab)

Board papers showed an increase in the numbers of BAME leaders at the trust from 2016 onwards. The table below indicated an increase in the number of BAME staff at Bands 8 and 9 over the past six months. The trust recognised that, based on the current trajectory, the employment target to have a senior workforce reflective of the local population by 2025 would be missed by around 8%. However, overall there had been some improvement from April 2019.



(Source- Board Papers-Integrated performance dashboard September 2019).

We found that senior leaders were experienced, visible and approachable, however not all were fully sighted on risks, issues and challenges to some services. Some of the senior team we spoke with were not aware of risks and issues in maternity services. This meant that leadership and governance at the trust did not always support the delivery of high quality, person centred care.

There was a clinical business unit which focussed on a leadership development programme. This was designed to develop leaders at all levels in the trust. The programme concentrated on

collective skills including quality improvement; inclusive leadership and demonstrating trust values. There were development pathways known as;

- Leading high performance
- Managing high performance, and
- Top up opportunities, which could be undertaken as standalone modules.

Before our inspection, we asked the trust how many staff had participated in a leadership development programme within the last twelve months and in the last full financial year. The table below shows how many people took part in leadership development over the last two years.

Number Participated	
Last 12 months (Year 2)	Previous Year (Year 1)
486.00	491.00

(Source RPIR- P54)

Senior leaders told us leadership development opportunities were open to all staff.

There was a developing programme of board visits to meet staff at their workplace. The visits would enable board members to speak to staff and consider their views and to gain assurance with safety and quality requirements. Front line teams told us that executive board members were visible and approachable. However, at the time of our inspection front line staff were unsure who the non-executive leaders of the trust were.

We carried out checks to determine whether appropriate steps had been taken to complete employment checks for senior leaders in line with the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014).
This regulation ensures that directors of NHS providers are fit and proper to carry out this important role.

During inspection we reviewed of the files of 14 senior leaders, including executive and deputy directors, and eight NEDs. Board members completed annual self-declaration forms to confirm that they complied with the regulation. Appropriate information was present in the files such as annual declaration in line with FPPR, references and bankruptcy and insolvency checks. This confirmed the trust was compliant with FPPR.

The trust did not have a board level lead for mental healthcare, however, the chief nurse's portfolio included dementia and learning difficulty.

The trust had reviewed the board development programme as the chair has recognised the programme was not fit for purpose. This was recognised following the non-executives initial one to one meetings with the chair. The revised board development focussed more on internal learning, and questioning, in addition looking at different areas of the trust including the newly opened Wolfson Centre.

Vision and strategy

There was a clear statement of vision and values. These were communicated through a clinical service strategy with defined strategic objectives. The strategic objectives were stated as;

- To provide outstanding care for patients
- To deliver the financial plan and key performance targets
- To be in the top 20% of NHS employers
- To be a continually learning organisation
- To collaborate effectively with local and regional partners

The clinical service strategy was aligned to local plans, and services were planned to meet the needs of the local population. We were provided with copies of the clinical service strategy (2017-2021). Within this the trust mission was described, 'to provide the highest quality healthcare at all times.' Senior leaders told us the clinical strategy was the main organisational strategy.

It had been shaped around four themes, each with specific actions. These themes and actions were;

High Quality Care

- provide high quality healthcare, 24 hours a day, 7 days a week
- take pride in being professional, compassionate and always putting safety first

Research led care and learning

- to make the trust a national exemplar for applying research findings to clinical practice and in improving the health of our population
- develop the trust further as a centre of learning excellence and professional development

Collaborative hospital care

- develop the trust as the hub for a range of specialised services in the west of West Yorkshire
- work with other providers of acute hospital care, to best meet the needs of our shared patient populations

Connected local care

- support people to stay out of hospital where appropriate or be safely discharged as soon as they are ready
- work with local partners to establish a responsive integrated care system
- ensure the trust remains closely connected to the community that it serves

A wide range of staff and stakeholders had been involved in the development of the mission, vision and values statements and the clinical service strategy between December 2016 and March 2017.

The clinical strategy was underpinned by eight enabling strategies; the diagram below taken from the clinical strategy demonstrates them.

Each of the underpinning strategies was aligned to a subcommittee of the board.

The people strategy 2017 – 22, outlined the trust's commitment to developing a modern workforce; with the skills, flexibilities, values and behaviours to deliver new models of healthcare and support the delivery of overall trust priorities. There were five strategic aims outlined in the strategy; attract, develop, retain, happy, healthy and here, and to lead. These included objectives around recruitment, engagement, staff development and equality and diversity. Progress against objectives was monitored through the workforce committee, which met every two months and was chaired by a non-executive director.

The health professional's framework 2017 and beyond laid out the commitment of the trust to ensure staff felt supported to make a difference and be innovative in their practice.

The quality plan 2019-2022 described the trust's approach to sustaining and enhancing the culture of continuous learning, innovation and improvement. In addition, it provided the trust with a strategic focus in the approach to quality, including staff engagement, and the measurement of improving care.

The education strategy 2019-2024, aimed to ensure there was an appropriately educated workforce, which was trained and skilled to deliver safe effective and efficient care to meet the needs of the local population.

The patient experience strategy, 'Embracing kindness (2018)' the overarching ambition for this strategy was for all staff to provide the best possible experience by embracing a spirit of kindness. This aim was to improve the process for patients and their families to share their experience of their care. In addition, it was intended for staff to understand and act on the experiences which were shared.

The trust did not have a strategy specifically for mental healthcare or for the care of people with a learning disability or autism. Managers told us that a learning disability strategy was planned for the future and would be the responsibility of a newly appointed lead nurse for learning disabilities. The trust's clinical strategy did not include reference to patients with a mental health problem, learning disability or autism.

There had been limited monitoring of progress with the overall strategy and it had not been refreshed since August 2017. However, we saw some monitoring had taken place. For example, a document "The Clinical Strategy: One year on" was presented and discussed at a board development session in September 2018. A care group and clinical business unit (CBU) structure was put in place in April 2019. There had previously been three clinical divisions. Following the CBUs being put in place, individual service development plans were being developed for each

CBU. The plans were intended to take account of information from sources such as the clinical service strategy, the NHS long term plan, and other data. The plans were known as 'service development intentions' for each of the clinical areas and would be the process by which the strategy could be delivered. We were not assured leaders at all levels had been held to account for delivery of the strategy.

Non-executive directors told us there had been an intention to review the strategy, but this was put on hold until a permanent chair and chief executive were in post. Governors we spoke with told us they perceived a reluctance to talk about a longer-term strategy, and that progress had been slow. They hoped the new board team would move this forward

Culture

Organisational culture can be described as 'how we do things round here'. A healthy culture in an NHS trust is crucial to ensuring the delivery of high-quality patient care.

We saw that leaders modelled and encouraged inclusive and supportive relationships among the workforce so that people felt respected valued and supported. Leaders encouraged positivity and pride in the organisation. Staff told us they felt appreciated and proud about working for the trust and within their teams. There was effective multidisciplinary working and teamwork for the benefit of patients. Staff we spoke with described an open, inclusive and honest culture. They told us they were supported and given opportunity to develop their skills to enable the delivery of safe care and treatment to patients.

We observed one board meeting and three committees throughout the year, as part of our ongoing monitoring. We saw there was mutual respect among leaders and managers. The executives and non-executive directors worked well together with the council of governors. During these meetings we observed appropriate and constructive challenge of both executive and non-executive directors. Although the chief executive had been in post for a short time prior to our inspection we were consistently told by senior leaders there now appeared to be a greater sense of shared responsibility by the board.

Freedom to speak up

We met with the deputy Freedom to Speak Up guardian. We found that freedom to speak up (FTSU) was embedded at the trust. Staff could raise concerns in several ways, including by emailing a secure email, or by downloading the FTSU free app and sending an anonymous message. Staff could also contact the FTSU associate guardians by telephone, email or in writing. There were 10 associate guardians, mainly in the nursing workforce. All concerns raised were recorded on an excel database. The database had been set up as per the national guardian office guidance and only the executive lead for FTSU, the FTSU guardian, and the deputy guardian, had access to the database.

Throughout any period of further investigation, the associate guardians supported the person who raised the concern. At the initial meeting the person raising the concern was informed that they would not suffer any detriment because of speaking up, and this was monitored throughout the support. Following any investigation, the FTSU associate guardian ensured that the recommendations were shared with the person who spoke up.

The guardian and their deputy met with the trust chairperson, the chief executive and a NED, in planned meetings. Cases and scenarios were discussed and ways to learn and take action from concerns that had been raised. A formal report was presented to the board twice a year.

The main themes around concerns raised over the last 12 months related to staff experiences of unacceptable values and behaviours and elements of bullying and harassment. Some concerns prompted formal investigation under a HR policy, or support from the staff advocacy service, via the staff experience manager/ support from the organisational development team. The organisation development team delivered bespoke sessions around trust values in departments on request from the FTSU team. The trust equality and diversity leader had worked to develop cultural ambassadors, due to a number of staff raising concerns relating to racism or racist comments.

In the 12 months from 13th August 2018 to 12th August 2019, there had been 53 'whistleblowing' concerns raised. From April to June 2019, there had been 10 referrals to the FTSU team; from July to September, there were 17 referrals, and from October to our inspection, there had been 13 referrals

Guardian of safe working

The guardian of safe working role was introduced in the NHS to protect patients and doctors by making sure doctors did not work unsafe hours. The trust had a guardian who acted as the champion of safe working hours. They monitored compliance with safe working hours at the trust by overseeing the staffing rota and working conditions. The addressed concerns relating to hours worked and access to training opportunities. Junior doctors submitted exception reports if they worked beyond contracted hours or educational opportunities were missed. The guardian escalated these reports to the chief medical officer and action was taken to reduce risks to the doctor or patients in their care. If there were persistent reports in a certain area, the guardian would undertake a work schedule review. The guardian worked closely with the director of medical education at the trust. The guardian monitored hours-related reports, while the director of education monitored training-related reports.

There were 319 exception reports submitted for the period 1 April 2018 to 31 March 2019. The majority related to additional hours worked in trauma and orthopaedics (94 reports), and medical areas (85 reports). Fifteen highlighted educational concerns, submitted by junior doctors in ophthalmology, obstetrics and gynaecology, general medicine, elderly medicine, general surgery and paediatrics. Additional hours worked could be recognised with a supplementary payment, time-off-in-lieu or no action.

(Source; Annual Report March 2019).

Duty of Candour

The trust had a duty of candour policy to guide staff on actions to be taken if they were involved in or witnessed a patient safety incident. All notifiable incidents were reported on the electronic reporting system. Assurance in relation to the completion of duty of candour was managed through the quality of care panel (if the incident was a serious incident) and through the incident performance management group for all other notifiable incidents. Compliance with the timescales associated with duty of candour was tracked through the quality governance team and reported quarterly within the patient safety report to the quality committee and within the integrated performance dashboard.

The trust received a fixed penalty fine from the CQC at the end of 2018, related to a breach in duty of candour regulations. They failed to apologise in a timely way after a serious incident. The trust added extra safeguards following the prosecution to prevent a reoccurrence.

(*Source: PIR-P30)*

Equality, diversity and inclusion.

There was strong commitment from leaders to support staff with protected characteristics under the Equality Act. The overarching clinical strategy did not contain any plans related to equality or inclusion; however, these formed parts of the people strategy 2017-2022. The trusts equality objectives had been previously launched in 2016 and were developed using internal and external engagement.

The equality objectives set out the eight priorities for the trust. They included compliance with the Accessible Information Standard, the Workforce Disability Equality Standard and the Workforce Race Equality Standard along with a focus on key areas such as gender pay gap and mental health awareness. We saw that progress against the equality objectives was monitored by the trust board twice a year.

There was an equality plan in place for 2019-2020 which identified several areas of work. All the polices we looked at and new service developments (clinical and non-clinical) had an equality impact assessment against the protected characteristics as described in the equalities act. The trust worked in partnership with the other NHS organisations in the region to host equality panels. These gave people from protected groups the opportunity to feedback to the trust on progress against the equality objectives.

There was a head of equality and diversity in place, and there were staff networks for Black, Asian and minority ethnic (BAME) staff, disabled staff and lesbian, gay, bisexual and transgender (LGBT+) staff.

The trust was working in partnership with local services to develop a hate crime reporting centre within the trust and training had taken place for some staff and volunteers. We heard of positive practice in relation to equality and inclusion.

Some examples included:

- Close work with partners to provide an accessible service for people with a learning disability. This included individualised care planning and membership of the local 'treat me well' (MENCAP) group. In October 2019 a lead nurse for learning disabilities was appointed.
- The trust worked with partners to provide bespoke access guides for people with disabilities accessing the locations of the trust.
- In October 2018 an accessible bathroom and changing facilities were opened for visitors with disabilities to use.
- The trust website could be translated into over 100 languages to allow information access to people whose first language was not English.
- 'MAMA' (mums and midwives academy) wallets were introduced within maternity services to provide women with information about reduced foetal movements and when to seek help. Leaders told us this supported women from the South Asian community.
- The trust launched the rainbow badge pledge scheme in September 2019. The national initiative aimed to promote a better understanding of LGBT+ specific issues and to foster an environment which embraced diversity and inclusivity for staff, patients and hospital visitors.

However, we found that no staff or volunteers received deaf awareness training, and there were no facilities for an assistance dog toileting area on the hospital sites.

Staff Diversity

As of May 2019, the trust provided the following equality and diversity update:

Workforce Disability Equality Standard (WDES)

Number of disabled staff in post

	Clinical		Non-Clinical		Not Declared
	Disabled	Non-Disabled	Disabled	Non-Disabled	
Bands 1-4	31	853	69	1295	285
Bands 5-7	82	1954	18	330	255
Band 8a-8b	4	160	5	71	16
Bands 8c, 8d, 9 and VSM	0	24	1	25	7
M&D Consultants	4	263	0	1	41
M&D Non-Consultants	0	79	N/A	N/A	8
M&D trainees	11	329	N/A	N/A	17

(Source: Routine Provider Information Request (RPIR) – P101 P102 RAE01 W.5.19.7 - Equality and Diversity Update - May 2019.doc

There was an action plan in place for the WDES report with actions to be completed from September 2019 to December 2020. Examples of actions included improving changing facilities for staff with disabilities and continued work with 'project search' which was a national pre-employment programme, to help young people with learning disabilities gain employment skills.

Percentage difference between the organisation's board voting membership and its overall workforce

	Total Board Membership	i.Voting membership	ii.Executive membership
Total	16	12	8
Non-Disabled	15	11	8
Disabled	1	1	0
Workforce	3.6%		
Disabled +/-	+2.65%*		

**This value refers to the percentage difference between the organisation's board voting membership and its overall workforce concerning disabled staff.*

(Source: Routine Provider Information Request (RPIR) – P101 P102 RAE01 W.5.19.7 - Equality and Diversity Update - May 2019.doc)

BAME Recruitment and Experience Targets

Regarding overall workforce, the trust stated that: "There are 5,881 staff in the trust of whom 5,757 have declared their ethnicity. There has been an overall increase of 0.9% in the proportion of BAME staff in the last 12 months. Whilst this is below our target of 1% each year, it still puts us ahead of trajectory for overall staffing numbers. If the current rate trajectory continues, we will exceed our overall BAME workforce target by around 4%."

	March 2019		March 2018		March 2017		March 2016	
	No	%	No	%	No	%	No	%
White	4,020	69.8	4,127	70.7	4,115	72.0	4,100	73.2
BAME	1,737	30.2	1,708	29.3	1,612	28.1	1,502	26.8

(Source: Routine Provider Information Request (RPIR) – P101 P102 RAE01 W.5.19.7 - Equality and Diversity Update - May 2019.doc)

The trust provided the following breakdown of staff by ethnic group:

Ethnic group	Medical and dental staff (%)	Nursing & midwifery registered staff (%)	Allied health professional staff (%)
White	53.9%	68.1%	77.4%
Mixed	2.5%	1.5%	2.1%
Asian	30.1%	14.1%	16.8%
Black	3.2%	3.3%	0.8%
Chinese	2.9%	0.2%	0.8%
Other	2.5%	10.6%	0.8%
Unknown / Not stated	4.8%	2.2%	1.3%
Total	**100.0%**	**100.0%**	**100.0%**

(Source: Routine Provider Information Request (RPIR) – Diversity tab)

Workforce race equality standard

The Workforce Race Equality Standard (WRES) became compulsory for all NHS trusts in April 2015. Trusts have to show progress against nine measures of equality in the workforce.

The scores presented below are indicators relating to the comparative experiences of white and black and minority ethnic (BME) staff, as required for the Workforce Race Equality Standard.

The data for indicators 1 to 4 and indicator 9 is supplied to CQC by NHS England, based on data from the Electronic Staff Record (ESR) or supplied by trusts to the NHS England WRES team, while indicators 5 to 8 are included in the NHS Staff Survey.

Notes relating to the scores:

- These scores are un-weighted, or not adjusted.
- There are nine WRES metrics which we display as 10 indicators. However, not all indicators are available for all trusts; for example, if the trust has less than 11 responses for a staff survey question, then the score would not be published.
- Note that the questions are not all oriented the same way: for 1a, 1b, 2, 4 and 7, a higher percentage is better while for indicators 3, 5, 6 and 8 a higher percentage is worse.
- The presence of a statistically significant difference between the experiences of BME and White staff may be caused by a variety of factors. Whether such differences are of regulatory significance will depend on individual trusts' circumstances.

WRES Indicators from ESR (HR data) [*]	BME Staff	White Staff	Are there statistically significant difference between...	
			BME and White staff?	Last year and this year? (BME staff)
1a. Proportion of clinical (nursing and midwifery) staff in senior roles, band 8a+	1.6%	7.3%	●	-0.2% ●
1b. Proportion of non-clinical staff in senior roles, band 8+	3.0%	6.4%	●	0.6% ●
2. Proportions of shortlisted candidates being appointed to positions	30.0%	44.3%	●	12.1% ●
3. Proportion of staff entering formal disciplinary processes	2.7%	2.6%	●	0.5% ●
4. Proportion of staff accessing non-mandatory training and CPD	29.4%	35.2%	Not assessed	

WRES Indicators from the NHS staff survey [**]		Proportion of respondents answering "Yes"			Are there significant differences between...		
		BME staff	White staff	All staff	BME and white staff?	This trust and its peer group?	Last year and this year? (BME)
5. Staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	Trust	25.5%	27.0%	28.3%	●	●	-2.2% ●
	Peer group	*29.9%*	*27.9%*	*28.7%*			
6. Staff experiencing harassment, bullying or abuse from staff in the last 12 months	Trust	23.8%	22.2%	22.7%	●	●	-3.2% ●
	Peer group	*30.1%*	*26.0%*	*27.0%*			
7. Staff believing that the trust provides equal opportunities for career progression or promotion	Trust	70.5%	87.1%	83.7%	●	●	2.4% ●
	Peer group	*69.8%*	*86.3%*	*83.3%*			
8. Staff experiencing discrimination at work from a manager / team leader or other colleague?	Trust	14.3%	5.7%	7.8%	●	●	-0.1% ●
	Peer group	*15.9%*	*6.7%*	*8.5%*			

Trust staffing numbers [*]	2018		2017	
9. [BME Voting Board Members] and Board compared to overall staff demographic	[3]	●	[3]	●

Key

- ● Statistically significant or negative finding
- ● Not statistically significant
- ● Positive finding
- ○ Statistical analysis not undertaken as less than 30 BME staff responded
- ▲ Statistically significant improvement
- ▶ No statistically significant change
- ▼ Statistically significant deterioration

As of 31/03/2018, the following three ESR staffing indicators showed a statistically significant difference in score between White and BME staff:

1a. In 2018, BME candidates were significantly less likely than White candidates to hold senior (band 8+) clinical roles (1.6% of BME staff compared to 7.3% of White staff). This decreased by 0.2% and remained similar when compared to the previous year, 2017.

1b. In 2018, BME candidates were significantly less likely than White candidates to hold senior (band 8+) non-clinical roles (3.0% of BME staff compared to 6.4% of White staff). This increased by 0.6% and remained similar when compared to the previous year, 2017.

2. In 2018, BME candidates were significantly less likely than White candidates to get jobs for which they had been shortlisted (30.0% of BME staff compared to 44.3% of White staff). This has increased by 12.1% and shows a statistically significant improvement when compared to the previous year, 2017.

The following two indicators from the NHS staff survey 2018, showed a statistically significant difference in score between White and BME staff:

7. 70.5% of BME staff believed that the trust provided equal opportunities for career progression and promotion (2018 NHS staff survey) which was significantly lower when compared to 87.1% of White staff. The score had increased by 2.4% and remained similar when compared to the previous year, 2017.

8. 14.3% of BME staff experienced discrimination from a colleague or manager in the past year (2018 NHS staff survey which was significantly higher when compared to 5.7% of White staff. The score had decreased by 0.1% and remained similar when compared to the previous year, 2017.

There were three BME voting board members at the trust, which was not significantly different to the number expected, based on the overall percentage of BME staff.

(Source: NHS Staff Survey 2018; NHS England)

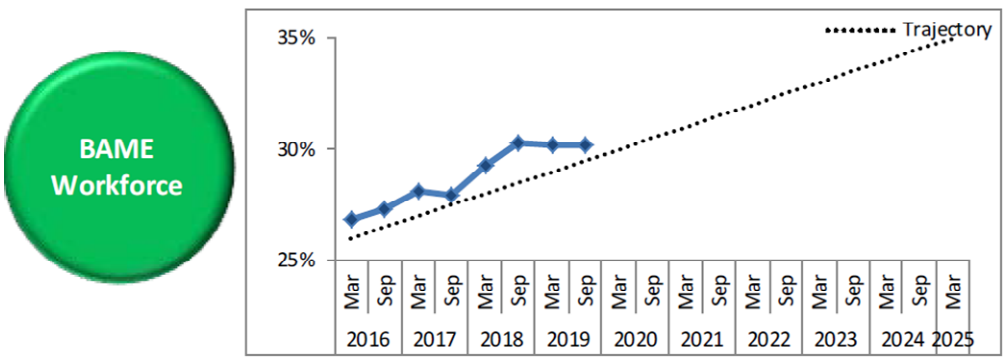
There was a WRES action plan in place. The action plan included;

- Work to equalise chances of BAME candidates being appointed to do jobs they have been shortlisted for.
- Work to determine why BAME staff are more likely to enter a formal disciplinary process
- Work to understand why white staff are more likely to access non-mandatory training. (it is the third year that figures indicate this).

Board papers indicated the trust worked on the perception that they were not an equal opportunities employer for career progression or promotion. However, it highlighted too the positive action being taken to address inequality where it existed. We saw there had been a reduction in staff experiencing abuse from other staff, and the trust was below the national average for this.

We were concerned that half of the action plans on the WRES action plan had no end date; they were stated as 'ongoing'. It was difficult to see when the trust planned to achieve certain actions.

We saw in board papers that the proportion of BAME staff in the workforce had remained static at 30.2% over the past 12 months. However, the trajectory put the trust ahead of its target of having a workforce reflective of the local population (35%) by 2025. The graph below demonstrates the trajectory.



(From integrated dashboard- board papers- September 2019)

Leaders told us the trust was introducing reverse mentoring and to narrow the gap at senior levels. Some senior BAME staff had received training to be part of the recruitment and selection process for all posts at band 8a and above.
(Source PIR)

Workforce Race Equality Standard (WRES)

Percentage difference between the trust's board voting membership and its overall workforce and executive membership and its overall workforce

	Total Board Membership	i.Voting membership	ii.Executive membership
Total	**16**	**12**	**8**
White	81.25% (13)	75% (9)	100% (9)
BAME	18.75% (3)	25% (3)	0% (0)
Workforce	30.16%		
% BAME +/-	-11.4%*		

**This value refers to the percentage difference between the trust's board voting membership and its overall workforce and executive membership and its overall workforce concerning disabled staff.*

(Source: Routine Provider Information Request (RPIR) – P101 P102 RAE01 W.5.19.7 - Equality and Diversity Update - May 2019.doc)

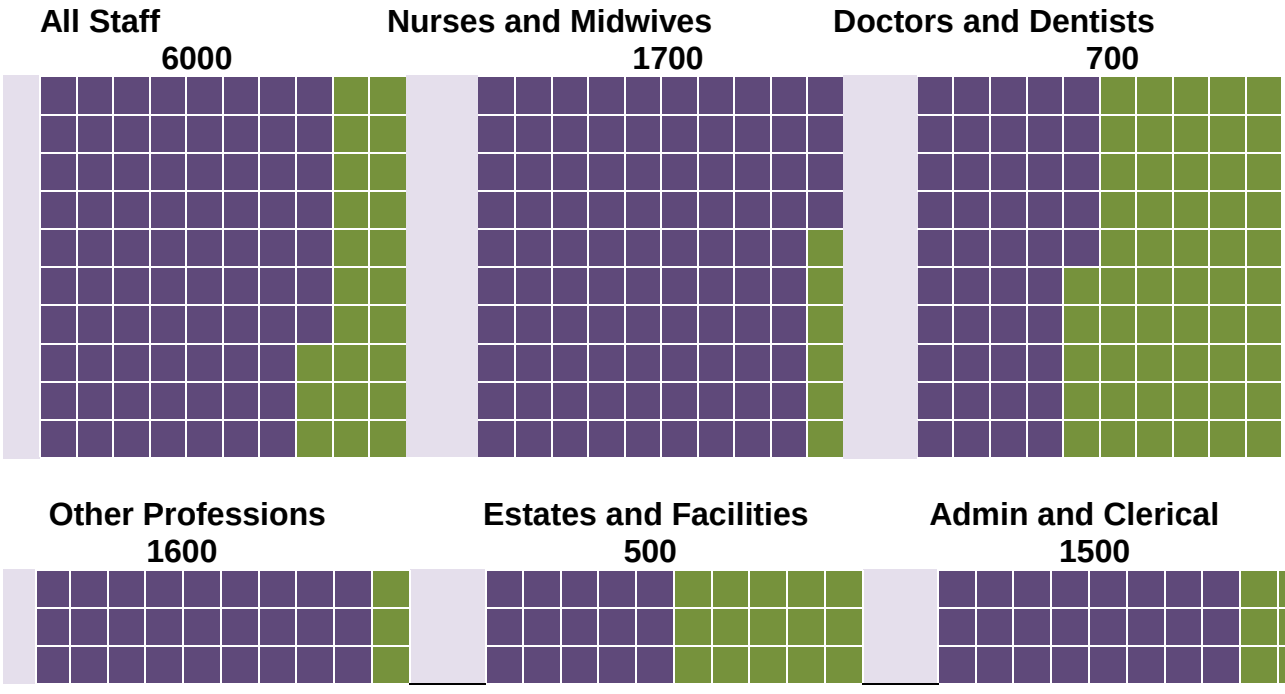
The trust has stated that: "Our overall percentage of BAME staff is 30.2%. This is an increase of 0.89% since our last WRES report was produced, which puts us ahead of our trajectory employment target of 35% for overall staff numbers reflecting the ethnic diversity of our local population."

(Source: Routine Provider Information Request (RPIR) – P101 P102 RAE01 W.5.19.7 - Equality and Diversity Update - May 2019.doc)

Gender Pay Gap

In 2018, it became mandatory for all public sector employers with more than 250 employees to measure and publish their gender pay gap.

The trust employed around 6000 people and like other hospitals, women made up most staff at 77%. The table below illustrates how the workforce is made up by gender. Each square represents one percent of the workforce in the different categories illustrated below, with purple showing female staff and green showing male staff.



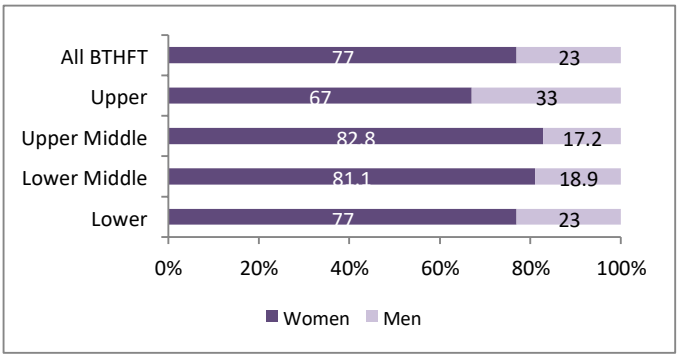
When it comes to pay, women earned less.

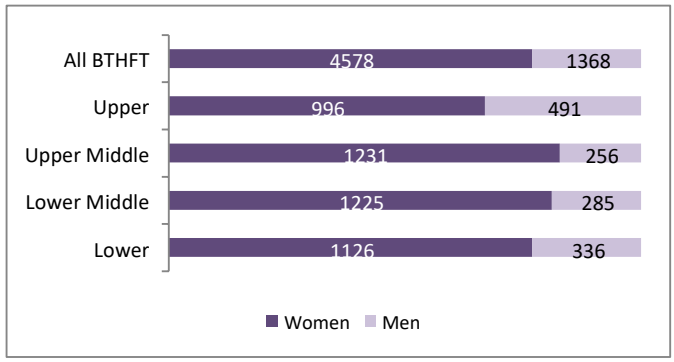
	Women's earnings are:
Mean gender pay in hourly pay – ie average	**31.34% lower**
Median[1] gender pay in hourly	**10.11% lower**

This means that on average, for every pound that men earned in the trust, women earned just over 69 pence. This was 4% worse than last year. The difference in the median pay was 10 pence per pound less for women, up from 3 pence last year.
For bonus payments, men earned on average nearly 40% more in bonuses than women.

	Women's earnings are:
Difference in mean bonus payments	**40.42% lower**
Difference in median bonus payments	**33.33% lower**

Bonuses were only paid to some senior doctors, more of whom are men than women. This was down over 5% last year.
The chart below shows female staff and all male staff ranked separately according to their pay. They were then put in to four quartiles with quartile 1 being lowest paid staff, 2 being lower middle, 3 being upper middle and 4 being highest paid staff.





Women were over-represented in quartiles 1, 2 and 3 and under-represented in quartile 4. The trust planned to work with the behaviour insights team to reduce the gender pay gap and bonus pay gap.
(Source: Trust gender pay gap report 2019)

Average and Median Pay Rate

Name of Trust	Women's Hourly Rate (Pay gap)		Diff +/-	Women's Median Rate (Pay gap)		Diff +/-
	2017	2018		2017	2018	
Airedale	31.2	37.1	+5.9	19.6	22.8	+3.2
Barnsley	30.0	37.5	+7.5	10.5	22.2	+11.7

[1] If all staff salaries are listed from lowest to highest, the salary in the middle of the long list of salaries is the median.

Name of Trust	Women's Hourly Rate (Pay gap)		Diff +/-	Women's Median Rate (Pay gap)		Diff +/-
	2017	2018		2017	2018	
BTHFT	**27.3**	**31.3**	**+4.0**	**3.2**	**10.1**	**+6.9**
Doncaster Bassetlaw	45.1	37.2	-7.9	28.4	25.7	-2.7
Doncaster Children's	13.1	11.0	-2.1	8.2	8.0	-0.2
Harrogate and District	25.4	31.8	+6.4	0.0	15.2	+15.2
Hull and East Yorks	32.9	30.7	-2.2	22.9	15.1	-7.8
Leeds Teaching	27.9	27.3	-0.6	9.4	9.1	-0.3
Mid Yorkshire	34.0	30.2	-3.8	21.8	16.3	-5.5
Rotherham	26.1	24.7	-1.4	13.8	10.6	-3.2
Sheffield Children's	20.2	23.6	+3.4	9.3	15.6	+6.3
Sheffield Teaching	24.1	23.7	-0.4	10.2	9.2	-1.0
York Teaching	28.7	27.7	-1.0	9.5	9.4	-0.1

The trust stated that "Comparing our performance to our regional neighbours we are 7th for hourly pay gap (out of 15). We have the 2nd lowest median pay gap."

(Source: Routine Provider Information Request (RPIR) – P101 P102 RAE01 W.5.19.7 - Equality and Diversity Update - May 2019.doc)

NHS Staff Survey 2018 results – Summary scores

The following illustration shows how this provider compared with other similar providers on ten key themes from the survey. Possible scores range from one to ten – a higher score indicates a better result.

The trust's 2018 scores for the following themes were significantly higher (better) when compared to the 2017 survey:

- Immediate managers
- quality of appraisals
- safe environment – violence
- safety culture and staff engagement

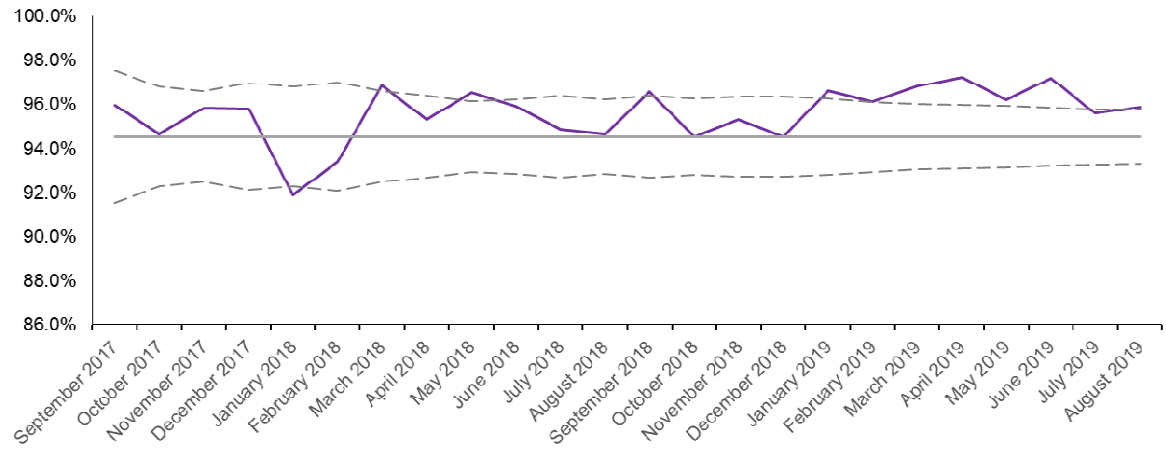
There were no themes where the trust's scores were significantly lower (worse) when compared to the 2017 staff survey.

(Source: NHS Staff Survey 2018)

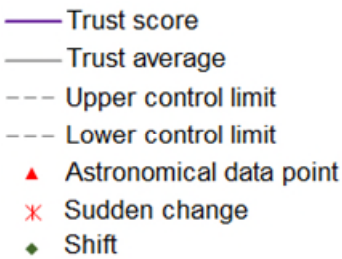
Friends and Family test

The Patient Friends and Family Test asks patients whether they would recommend the services they have used based on their experiences of care and treatment. The trust scored between 91.9% and 97.2% from September 2017 to August 2019. The data appears to be unstable and may be subject to ongoing change.

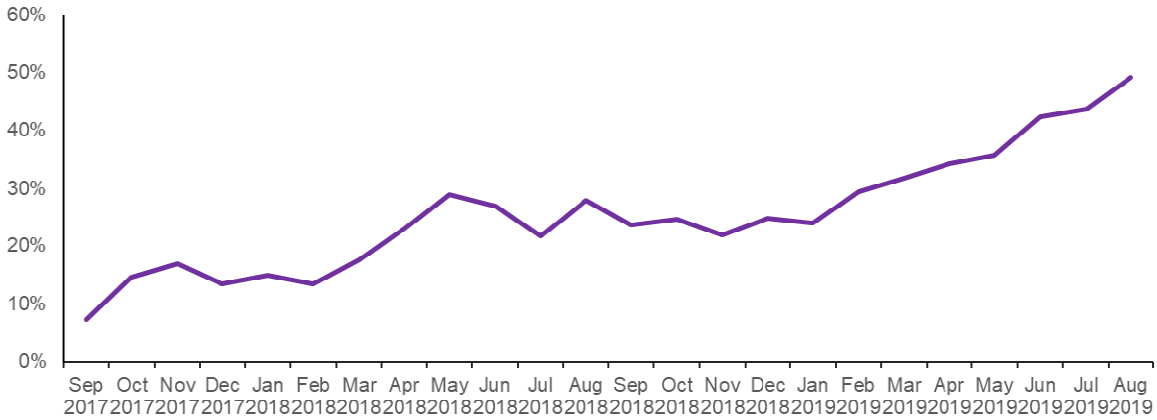
Bradford Teaching Hospitals NHS Foundation Trust - Friends and family test performance – September 2017 to August 2019



Note: there were no astronomical data points, sudden changes or shifts as the performance had too few runs and was not stable.



Bradford Teaching Hospitals NHS Foundation Trust response rate (September 2017 to August 2019)

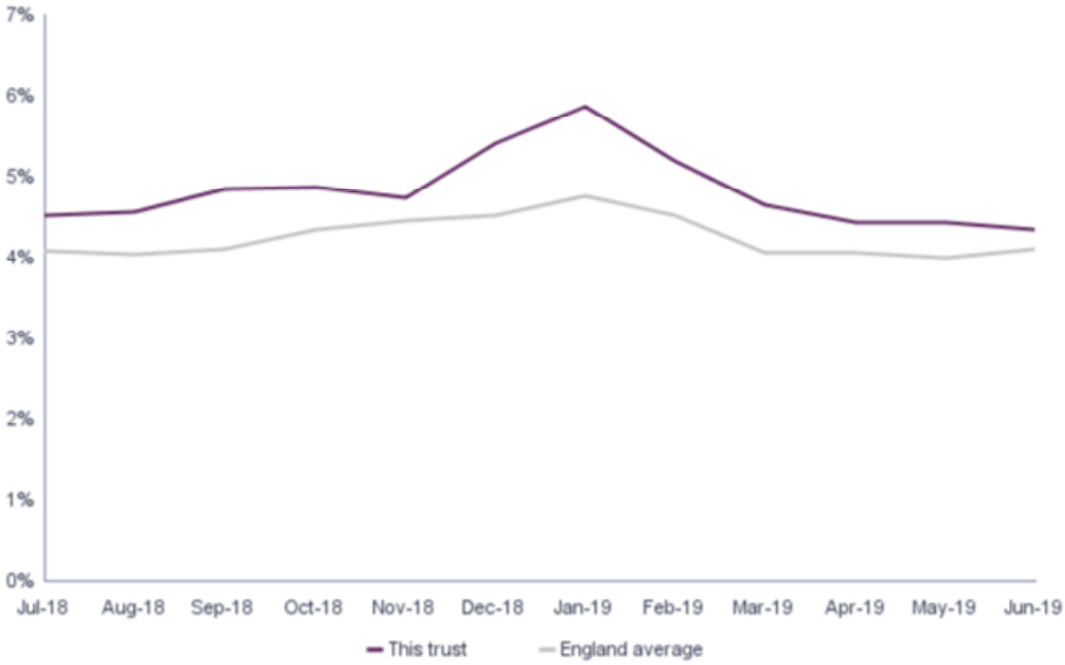


The above chart shows that from September 2017 to August 2019 the response rate for the trust has generally increased throughout the period.

(Source: Friends and Family Test)

Sickness absence rates

The trust's sickness absence levels from July 2018 to June 2019 were higher than the England average throughout the period.



(Source: NHS Digital)

General Medical Council – National Training Scheme Survey

In the 2019 General Medical Council Survey the trust performed the same as expected for all indicators apart from the indicator concerning 'local teaching' where it was worse than expected.

Better than expected Same as expected Worse than expected

Survey area	RAG
Curriculum coverage	○
Educational governance	○

Reporting systems	
Rota design	
Teamwork	
Overall satisfaction	
Clinical supervision	
Clinical supervision out of hours	
Handover	
Induction	
Adequate experience	
Supportive environment	
Work load	
Educational supervision	
Feedback	
Local teaching	
Regional teaching	
Study leave	

(Source: General Medical Council National Training Scheme Survey)

Accessible Information Standard

Since 1st August 2016, all organisations that provide NHS care and / or publicly-funded adult social care have been legally required to follow the Accessible Information Standard (AIS). The standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents with a disability, impairment or sensory loss. The trust was not fully compliant with the standard, however there were some measures in place.

The trust website had links to an accessibility 'side bar' enabling the fonts, colours and lighting to be adapted. The trust was also in partnership with an external organisation to provide detailed information for people with disabilities on how to access trust sites (including ramps, toilets etc.) and this website used technology to comply with the AIS.

The trust undertook a further review of progress towards meeting the AIS in July 2019, to determine the level of maturity of their systems, particularly since the implementation of electronic patient records (EPR). They attended a CQC workshop in July 2019 related to AIS. Following that, the trust set up a working group to progress compliance with AIS. Early work had been in relation to the EPR

and the information sent out as part of appointment letters. In addition, the implementation of EPR improved the mechanism for recording and flagging of needs, which had improved the visibility and sharing of such information. The information about communication needs could be seen by all staff accessing the patients record and pulled through automatically for each encounter.

The EPR system was linked to a third-party provider of correspondence who sent out letters for most appointments. Where a patient had identified the need for large print for example, this would automatically be applied to the letters for that patient. Some of the clinical information systems were not linked directly to the third-party provider, so work was underway to establish direct links from the other systems.

In terms of the capability of the trusts systems, they self-assessed compliance with AIS as being intermediate on the NHS England maturity index. Although their system had automated capability, it relied on staff awareness about AIS to use the system effectively. The trust was aware further work was required, and there were staff updates planned from September 2019 onwards.

Governance

Governance describes the ways that NHS organisations ensure they run themselves efficiently and effectively.

There was a clear governance structure at the trust, with processes and systems of accountability. This allowed for escalation of information and key risks to the trust board through various committees and assurance groups.

The governance structure included foundation trust members, the council of governors and the trust board.

The main sub-committees of the board were;

- Quality committee (met monthly)
- Audit and assurance committee (every two months)
- Finance and performance committee (monthly)
- Workforce committee (every two months)
- Partnerships Committee (monthly)
- Major projects committee (every two months)
- Remuneration committee (at least annually)

There had been a review of the committees in 2019 and this resulted in changes to the terms of reference of the committees.

All sub-committees of the board were chaired by a non-executive director (NED) and had clear terms of reference. The trust board and sub-committees received detailed, high quality information through periodic reports, summary briefings and integrated dashboards to inform planning and decision-making.

We were concerned about weak governance in maternity. We were not assured all levels of governance and management always functioned effectively in this clinical area. Senior leaders and managers had failed to monitor or improve performance in a number of fundamental areas of care. For example, there were ongoing midwifery staffing challenges in the service, and we observed poor levels of one-to-one midwifery care in established labour, and hourly ‘fresh eyes’ reviews of CTGs.

We saw that board papers included very large numbers of papers with significant detail in, including important internal trust reports and national briefings from NHS England. In September 2019, there

had been 72 board papers and appendices for board members to read and digest before the meeting; in November 2019, there had been 79 similar papers and reports. We were concerned about the challenge for board members to read and process large amounts of information. One board meeting we attended before the inspection ran over time due to the amount of information to be discussed and agreed.

The audit and assurance committee usually met every two months. There were no minutes on the trust website after the May 2019 meeting, so we requested them from the trust after our inspection. There had been a second committee meeting on 23 May 2019, two days after the planned meeting. The trust told us the extra meeting was to approve an annual report, but minutes from the meeting on 23rd May indicated standard agenda items were discussed including the counter fraud report and the internal audit report. We were concerned there was so much information at the committee on 21st May, that it could not all be processed in the allotted time which meant governance arrangements did not always operate effectively.

The next planned meeting of the committee took place in July 2019; however, the October meeting was cancelled. This meant that committee actions were not taken forward for the November board meeting. Minutes from the December meeting were not available for us, we were told they would be ratified at the next meeting in February 2020. This indicated some gaps and weakness in the governance processes.

There were two additional executive led committees that fed in to the trust board; the integrated governance and risk committee and the health and safety committee.

A care group and clinical business unit (CBU) structure was put in place in April 2019. The main aim was to develop a system of autonomy and governance so that the CBUs would be responsible for their performance. The changes meant there was local decision making and more clinical ownership. Senior leaders described each CBU as clinically led, and managerially supported. A triumvirate of a nurse, a doctor and a general manager was in place at each CBU.

There was a council of unpaid governors which was a collective body through which executive and non-executive directors explained and justified their actions. The governors worked with the trust board to make sure services were meeting the needs of the local community. The council was chaired by the trust chairperson, as this was a legal requirement. There were 19 governor seats incorporating public, staff, partner, and patient governors.

The principal role of the council of governors was to hold the non-executive directors to account for the performance of the board of directors and to represent the interests of the trust members and the public. The board was responsible for the direction and performance of the trust, while the council of governors was responsible primarily for assuring the performance of the board.

Safeguarding

There were robust safeguarding procedures in place at the trust and safeguarding plans were person centred. The chief nurse was the executive lead for safeguarding adults and children. The deputy chief nurse had operational responsibility for the named safeguarding professionals for both adults and children. There was also a part time senior midwife and full-time midwife with safeguarding responsibilities. The sub groups for adults and children were responsible for overseeing the detail of policy development, and review of safeguarding activity. They also had oversight of the audit of practice and training compliance, along with ensuring that updates were received from the relevant safeguarding boards. The sub groups made sure processes were in place for learning lessons from serious incidents, serious case reviews / domestic homicide reviews or other significant events.

The integrated safeguarding committee was chaired by the deputy chief nurse. This group met quarterly and provided assurance that legal requirements and national guidance were incorporated into trust policies and processes. The committee reported into the quality committee, and through that the trust board, with assurance the trust was meeting its obligations. The assurance was via the annual safeguarding report, and other reports and audits, with escalation as appropriate. The committee also provided assurance that the trust complied with the 'Looked After Children' standards and responsibilities.

The chief nurse was the vice chair of the Bradford safeguarding adults board. The trust's named nurse for adults was an active partner on the sub committees of that board and chaired the multi-agency safeguarding adults' reviews.
The trust's named nurses for children were active partners on the 'Working Together to Safeguard Children – The Bradford Partnership' board (formally known as the Bradford safeguarding children's board). Both the trust's adults and children's teams worked closely with other statutory bodies and led some of the safeguarding initiatives (see innovation section later in this report).

The safeguarding adults and children's teams provided a training strategy in line with national guidance for the whole workforce, with designated levels of training for staff dependent on their role. Training was provided via e-learning and face-to-face sessions and included learning from serious case reviews and serious incidents. There was a newsletter every six months which was circulated to all staff.

The safeguarding teams were supported by over 30 champions who worked in a range of clinical areas at the trust. The champions were given two hours dedicated time a week to undertake safeguarding roles. There were clear processes for front line staff to report safeguarding concerns. Overall, staff at the trust understood their responsibilities and had the knowledge and resources to identify adults or children at risk who may need protection, and to identify individuals who may pose a risk to others.

Infection prevention and control

There were clear governance processes in place for infection prevention and control. An annual infection prevention and control (IPC) report was prepared by the director for infection and prevention control (DIPC) and submitted to the trust board. The chief nurse had the role of DIPC. They produced an IPC performance report every three months. Monthly IPC committee meetings took place with input from associated groups (such as antimicrobial prescribing and decontamination). The IPC committee reported in to the patient safety sub-committee and also to the quality committee.

Board assurance

Senior leaders told us that ward to board assurance was achieved primarily through effective use of data, and by patient and staff engagement. There was an established programme of engagement activities with staff. These were structured to ensure appropriate spread across clinical areas and included leadership walkarounds, and 'time to talk' sessions with staff. There were also board workshops with individual services, and a development programme for governors.

The governance infrastructure focussed on providing assurance that the trust was achieving the strategic objectives and effectively mitigating any risks. At board level, this was enabled by the integrated dashboard and board assurance framework. The care groups and CBUs used a 'balanced scorecard' which was aligned to the integrated dashboard. This enabled care groups to understand the quality of care they provided.

Board Assurance Framework

The board assurance framework (BAF) brought together in one place all the relevant information on the risks to the board's strategic objectives. The trust provided their BAF which detailed the following six strategic objectives:

1. To provide outstanding care for patients
2. To deliver the financial plan
3. To deliver the key performance targets
4. To be in the top 20% of employers in the NHS
5. To be a continually learning organisation
6. To collaborate effectively with local and regional partners

(Source: Routine Provider Information Request (RPIR) – P106 RAE01 Board Assurance Framework - Quarter 1 Final Version.doc)

These strategic objectives were the same as those in place on our last inspection, although we found the trusts assurance level had changed since then. The trust used four levels of assurance in their board assurance framework, indicated in the table below.

Levels of assurance		
little or no confidence	Low. No evidence of necessary structure/processes supporting mitigation of risk associated with the achievement of strategic objective	Risk
limited confidence	Compromised. Limited evidence of necessary structure/processes mitigation of risk associated with the achievement of strategic objective	Risk
confidence	Confident. Range of structures and processes in place supporting mitigation of risk associated with the achievement of strategic objective available and used by the organisation	Opportunities for change and improvement
High Confidence	Trust. Comprehensive evidence of effective and sustainable mitigation of risk associated with achievement of the strategic objectives	Opportunities for learning

The levels of assurance for the strategic objectives for quarter 2, 2019/ 2020 were;

To provide outstanding care for patients	confidence
To deliver the financial plan	limited confidence
To deliver the key performance targets	limited confidence
To be in the top 20% of employers in the NHS	confidence
To be a continually learning organisation	confidence
To collaborate effectively with local and regional partners	confidence

(source BAF: quarter 2, 2019/2020. Board papers. September 2019)

The BAF and corporate risk register set out the strategic risks that could impact on the delivery of the trust's objectives. The BAF and corporate risk register were reviewed by the trust board to gain assurance that the strategic risks (and the controls in place to manage the risk) were appropriate and effective.

Individual factors on the BAF were reviewed by the committees of the board. The board then received assurance from the committees and undertook a review of all BAF risks every six months. We saw key risks to the strategic objectives were recognised by the trust leadership and this was represented on the board assurance framework.

The BAF identified that there was confidence in four of the six objectives;

- the systems, process and outcomes to aspire to deliver outstanding care
- controls in place for delivery of work plans and effective controls in place
- evidence presented around being a learning organisation, which demonstrated progress made and further opportunities for improvement
- partnership work and effective mitigations.

There was limited confidence in;

- the financial plan, given the quarterly improvements needed to achieve the year end deficit control total
- delivery of key performance targets such as the four-hour emergency care standard due to a lack of physical capacity and insufficient clinical decision makers in the emergency department.

There were action plans in place to address gaps in both assurance and control.

Management of risk, issues and performance

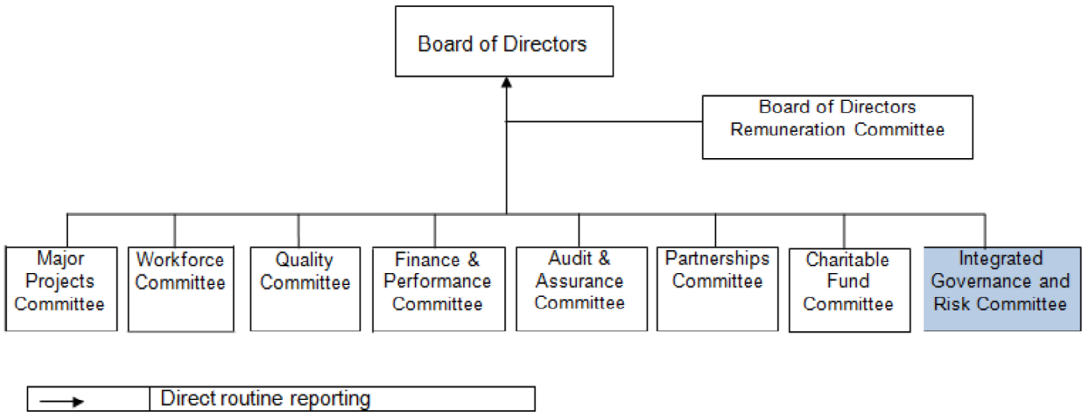
Risk

There had been a risk strategy (2017– 2020) in place at our previous well led inspection of the trust. It had articulated the trust's approach to managing risks. We could not find a risk strategy in place during this inspection, and it was not part of the underpinning strategies of the clinical strategy.

There was not always alignment between risks and senior leaders 'worry lists.' When we asked senior leaders about the top three risks for the trust, we were given differing responses. For example, one NED told us the top risks were the finance control total, endoscopy capacity/ cancer waiting times, and the shortage of microbiologists. An executive director told us the top risks were the emergency department, winter pressures and the risk of workforce 'burning out'.

There were assurance systems in place and performance issues were escalated appropriately through clear structures and processes. The trust board were accountable for risk management and were responsible for reviewing organisational risks through the corporate risk register and strategic risks through the board assurance framework. The corporate risk register at the trust was known as the strategic risk register, it included both strategic and organisational risk.

Risks were calculated using a risk matrix and framework based on the likelihood of the risk occurring and the severity of impact. Any risks entered on to the risk register were assigned a risk rating. Each risk had an initial, current and a target risk rating. The date that risks were added was included, and review dates were seen. Each risk had existing controls, gaps and mitigating actions. The integrated governance and risk committee was responsible for assuring the board that arrangements for integrated governance and risk management were consistent, comprehensive and effective. The diagram below (taken from committee terms of reference) shows the route of reporting to the board.



Principal risks were managed actively through a strategic risk register and were used to add context and assurance within the board assurance framework.
The integrated governance and risk committee reviewed all strategic risks each month, ensuring appropriate mitigation was in place. The other board committees reviewed elements of the BAF and the strategic risk register for which they have a defined assurance role, prior to its use at each meeting of the trust board.

Trust corporate risk register

The trust provided a document detailing their open strategic risks as of 04/09/2019. The table below shows each risk with a current risk score of either high or extreme.

Assuring Committee (s)	Date risk opened	ID	Description	Risk score (current)
Quality	16/01/2018	3203	There is a risk that the trust will not be compliant with aseptic and cytotoxic drug production standards due to the age and condition of the current aseptic and cytotoxic facility.	High
	07/02/2018	3211	There is a risk to patient safety from not delivering the national standards for cancer patients.	High
	04/01/2019	3313	There is a risk that the plan to repatriate tuberculosis (TB) testing work from the trust will be delayed if the equipment is not in place.	High
	15/05/2018	3240	There is a risk that patients may suffer clinical harm as a result of a process failure in the referral to treatment pathway. This has arisen as staff are not following the correct processes within electronic patient record.	High
	13/03/2019	3370	There is a risk of patient harm due to non-compliance with the safety standards for invasive procedures in a non-theatre environment.	High
	06/02/2017	3047	There is a risk that because the pathology joint venture is using a pathology Laboratory Information Management	High

			System (LIM) that is only used at one other site, is not well supported by the supplier and the primary support is via two people.	
	31/05/2017	3104	There is a risk that there may be total or partial failure of the telephony system.	High
	07/12/2016	3103	There is a risk that cyber security attacks to healthcare organisations could increase.	High
	10/04/2019	3380	There is a risk that patients with a mental health diagnosis may not be treated appropriately due to a lack in staff knowledge/awareness and provision of expert clinical advice.	Extreme
	13/12/2017	3169	There are a growing number of medicinal products, sourced on contracts, showing as out of stock with suppliers.	High
Quality, Workforce	21/07/2016	2968	There is a risk to delivery of the trust-wide microbiology service due to inability to recruit to consultant microbiologist posts.	Extreme
	11/03/2019	3369	There is a risk that following the resignation of four consultants within the infectious disease services together with two current vacancies within the microbiology service that from week commencing 13/05/2019 that the service cannot function in its current form.	Extreme
Health and Safety, Quality, Workforce	05/04/2019	3378	There is a risk that due to the lack of appropriate training, situations involving violent and aggressive patients requiring the de-escalation or ultimately restraint will not be managed effectively or safely resulting in harm to patients and/or staff.	Extreme
Health and Safety, Workforce	10/08/2018	3263	There is a risk of injury to patients, staff and others as a result of: 1 Staff inappropriately using medical devices due to staff not receiving appropriate training. 2 Staff not undertaking manual handling tasks correctly due to not receiving appropriate training in manual handling techniques.	High
Finance and Performance, Quality, Workforce	24/02/2019	3359	There is a risk that unforeseen implications related to a ‘no deal’ exit from the European Union will have an impact on services provided by the trust.	High
Quality	22/02/2019	3357	There is a risk that we are not fully compliant with revised regulatory requirements for ventilation within theatres leading to an increased risk of infection.	High
Finance and Performance, Quality	25/06/2018	3260	There is a risk that there is a lack of understanding of the full depth and breadth of clinical and medical service interactions and dependencies with Airedale Foundation Trust.	High
Health and Safety	27/09/2018	3288	There is a risk that the trust’s management of clinical waste will be non-compliant with	High

			health care waste management legislation which will result in harm to patients, staff, reputation and the environment following the cessation of the external clinical waste management solution	
Major Projects, Workforce	04/02/2019	3350	The risk of service disruption resulting from trade unions balloting members to recommend the commencement of industrial action as a result of the foundation trust board of directors approving the decision to create a wholly owned subsidiary for the provision of estates and facilities services.	Extreme
Major Projects, Workforce	04/02/2019	3349	The risk of reputational damage as a result of the foundation trust progressing with the proposal to create a wholly owned subsidiary to provide estates and facilities services.	High
Finance and Performance, Quality	24/07/2018	3270	There is a risk that patient harm could be caused where surgical and non-theatre procedures are not booked because of incorrect mapping on Cerner electronic patient record.	High
Finance and Performance, Quality	23/10/2017	3154	There is a financial and reputational risk to the trust following the deferral of joint advisory group on gastrointestinal endoscopy (JAG) accreditation pending the completion of key actions for the endoscopy unit.	High
Audit and Assurance	02/12/2015	2683	There is a risk that poor quality of external data submissions (including national clinical audit) will result in action against the trust.	High
Finance and Performance	22/05/2019	3399	The trust has insufficient cash & liquidity resources to sustainably support the underlying income & expenditure run rate.	High
	22/05/2019	3400	Failure to maintain financial stability and sustainability in the current economic climate with the trust facing a continued financial challenge associated with cost inflation, increased demand for services and commissioner affordability.	High
Finance and Performance, Quality	22/05/2019	3401	The requirement to maintain equilibrium between financial sustainability and delivering safe quality services is compromised by the economic challenge faced and the increasing internal and external demands to improve the quality and safety of the services provided.	High
Finance and performance	03/02/2017	3046	There is a risk that since 2010, the enterprise agreement with licensing bodies which was paid for centrally has been devolved to trust level.	Extreme
Finance and Performance	22/05/2019	3398	Failure to deliver the obligations within the NHS standard acute contract will result in	High

			the application of financial penalties and/or the failure to recover planned income.	
Partnerships	09/05/2019	3395	A risk that the trust continues to operate a non-compliant vascular service for an extended period pending validation of the West Yorkshire Association of Acute Trusts (WYAAT) arterial centre decision and delays in the operationalisation of a robust WYAAT single vascular network, meaning our vascular (arterial) surgery services are potentially no longer commissioned.	High
	28/06/2019	3255	Lack of agreement between the two trusts (Bradford Teaching Hospitals NHS Foundation trust and Airedale Foundation Trust, AFT) on the nature and scope of collaboration.	High
	24/04/2017	3090	There is a risk that local (i.e. Bradford) integrated care proposals destabilise existing trust arrangements without compensatory benefits for service users.	High
	24/04/2017	3091	There is a risk that decisions of West Yorkshire and Harrogate Health and Care Partnership (WYHP) and/or West Yorkshire Association of Acute Trusts (WYAAT) lead to enforced actions which the board might consider are not in the best interests of the local patient population, or which could impact adversely on trust operations / finance / service viability and so hinder delivery of clinical strategy.	High
	23/10/2017	3153	There is a risk that NHSI's proposals for consolidating pathology services in West Yorkshire around a single Hub (Leeds) and five spokes would put at risk the joint venture for pathology with Airedale NHS FT.	High
Health and Safety	07/02/2017	3142	There is a risk to staff safety that the ceiling of the medical records storage block could collapse due to an excess of medical records and poor physical integrity of the building.	High
	24/03/2016	2841	There is a risk that the trust is failing in its statutory duty of care in relation to management of healthcare waste due to poor waste segregation practice and could face prosecution for breach of health & safety legislation.	High
	15/03/2017	3068	There is a financial, reputation and safety risk as the trust is non-complaint with the Carriage of Dangerous Goods Regulations 2009.	High

(Source: Routine Provider Information Request (RPIR) - P106 RAE01 Open Strategic Risks (as at 4 September 2019).xlsx)

After the trust provided us with the above strategic risk register for September 2019, we reviewed board papers for the updates published in the November board papers. We saw the risk register of all open risks was dynamic, the category of some risks had changed during that time. There were some new high risks, such as the risk of duplicate patient care records. There were new extreme risks such as the risk of patients coming to harm due to insufficient endoscopy capacity. We were concerned that one previously rated extreme risk on the register in September was not on the risk register in November, and it was not clear what action had been taken to necessitate its complete removal from the register. (Risk number 3378- related to the lack of appropriate training for situations involving violent and aggressive patients).

Finances Overview

Financial metrics	Historical data		Projections	
	Previous Financial Year (2017/18)	Last Financial Year (2018/19)	This Financial Year (2019/20)	Next Financial Year (2020/21)
Income	£401.4m	£411.1m	£424.2m	£445.7m
Surplus (deficit)	£6.4m	£6.4m	£0	£0
Full Costs	-£395.0m	-£404.7m	-£424.2m	-£445.7m
Budget (or budget deficit)	£2.0m	£2.8m	£0	£0

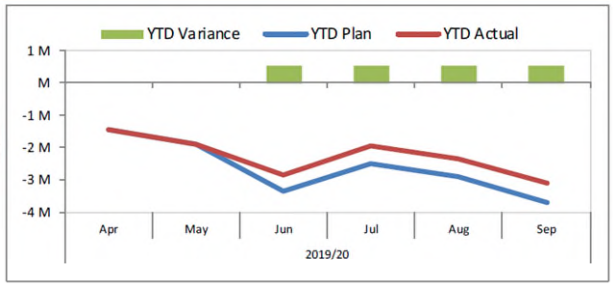
The surplus reported in 2018/19 of £6.4m was the same as the previous year. Projections for 2019/20 indicate that this surplus will decrease to a zero balance. This is also the case for 2020/21 projections.

(Source: Routine Provider Information Request (RPIR) – Finances Overview tab)

Finance- Control totals

NHS England and NHS Improvement introduced a capped expenditure process in 2016/17 to provide tighter controls on NHS spending to respond to financial pressures.
Control totals are annual financial targets that must be achieved to unlock access to national funding and other financial benefits. All NHS trusts are offered a control total that they can accept or reject. Access to the national sustainability and transformation funding is conditional on providers agreeing and delivering their control total.

Senior leaders told us the trust results that were either equal or better than the allocated pre-provider sustainability fund (PSF) total. As a result, the trust recovered bonus PSF values which, for the previous two years equated to additional income of (£5.8m for 2017/18 and £6.7m for 2018/19). The graph below, taken from the integrated dashboard (September 2019) shows the trend for delivery of income and expenditure.

Metric / Status	Trend
Delivery of Income and Expenditure Plan	

For 2019/20, the control total excluding PSF was a deficit of £12.5m. The trust told us they forecast delivery of the control total, however said there was a risk to delivering the required level of efficiencies. The trust was collaborating with local system partners to address the shared system financial challenges and had entered into a fixed income contract with the host CCGs for 2019/20.

Board papers (the integrated dashboard) from September 2019 detailed that the forecast presented to NHS Improvement represented full delivery of the £12.5m deficit. However, an internal trust forecast suggested a most likely deficit of £19.5m at year end. The care groups had been tasked with developing detailed recovery plans for executive review and implementation in early November 2019. Board papers stated the risk to control total delivery in 2019/20 was "significant". The trust had delivered £5.3m of efficiencies by 'month 6' (September 2019) which was in line with plan. However, CBUs and corporate management teams had recorded only £3.4m of recurrent savings. If that position remained unchanged, it would leave the trust short of its efficiency target for 2019/20, jeopardising delivery of the control total; hence the forecast for a likely deficit of £19.5m.

Over recent years the trust invested surplus cash into its capital programme. For example, £85m over the last 5 years including £28m on a new hospital wing and £19m electronic patient record, both of which were, in part, supported by capital loans. We saw the trust demonstrated investments into innovative models of care and technology to improve operational productivity.

The trust had commenced and invested in an acute provider collaboration programme with another local NHS trust with a focus on developing a joint clinical strategy to deliver stable, clinically sustainable, and cost-effective services across acute hospital sites at each trust. A joint 'place based' finance and performance committee was created to jointly monitor and manage system delivery of the financial and performance challenges. Accountability for delivery of this was held by the numerous sub groups which included both the urgent care and planned care boards at the trust. *(Source PIR; Finances P59 and Integrated Dashboard, September 2019).*

A use of resources assessment was carried out by NHS England/ Improvement; this is published as a separate document along with this inspection report.

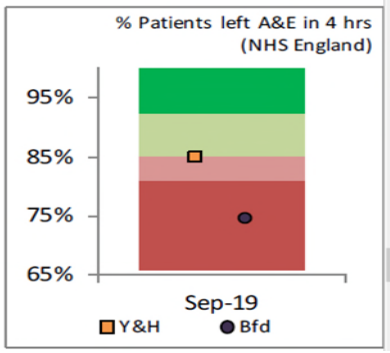
Performance

There was an integrated dashboard which measured performance against a range of objectives and performance indicators; the dashboard was used to cover areas related to the strategic objectives. A sample of some of the indictors is shown below.

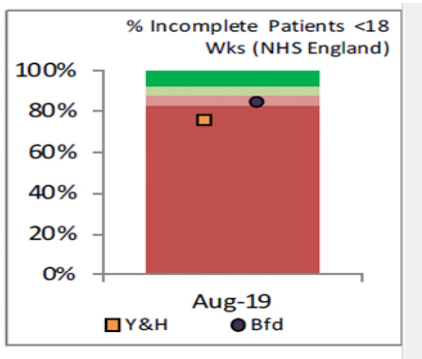
Emergency care standard:

Performance in the emergency care standard (patients leaving the emergency department within four hours) had decreased overall in recent years in line with the national trend. Performance in September 2019 was 74.7% against a 95% target. Senior leaders told us there was a continued focus on strengthening patient flow through the department.

The trust benchmarked itself against other trusts in the region; the graph below indicates the average performance in the region was 85% in that month.



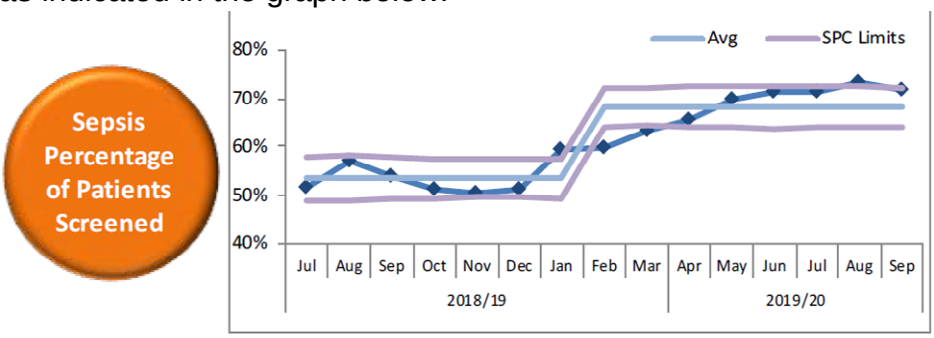
Referral to treatment times (RTT):
Performance against the 'incomplete' RTT pathways had improved in September 2019 to 84.8% but it was below the improvement trajectory. Leaders told us this had been because of an increase in annual leave, and capacity gaps across several specialties. (Incomplete pathways represent those patients who have been referred on to consultant-led RTT pathways, but whose treatment had not yet started). The graph below shows performance at the trust was better than the average in the region.



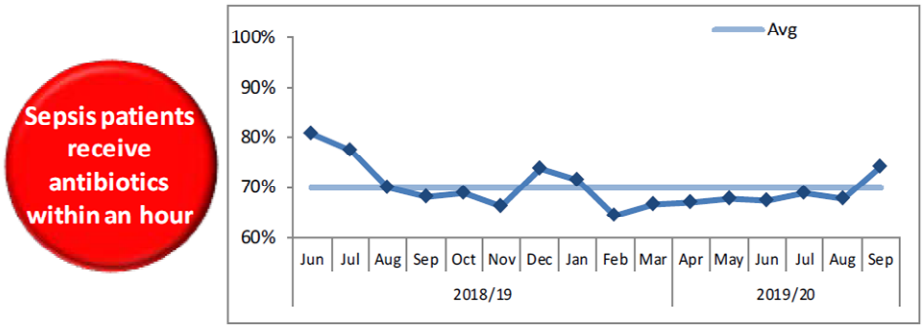
The total waiting list increased by 760 patients, mainly for patients waiting less than 18 weeks. There were no patients waiting more than 52 weeks for treatment at the end of September 2019.

Infection prevention and control:
There had been good performance in the low numbers of Methicillin-resistant Staphylococcus aureus (MRSA) and catheter associated UTI indicators. The numbers of infections related to Clostridium difficile had increased, leaders told us this was due to national changes to reporting

Sepsis: there had been a trajectory of improvement in the numbers of patients screened for sepsis as indicated in the graph below.

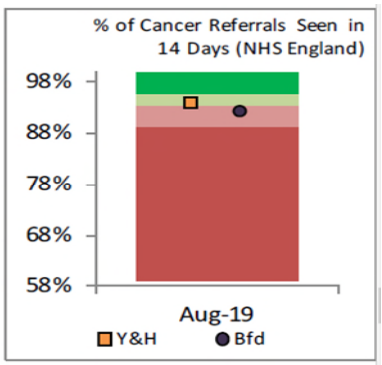


However, the numbers of patients with sepsis who received antibiotics within an hour had reduced over the same time, as indicated below.

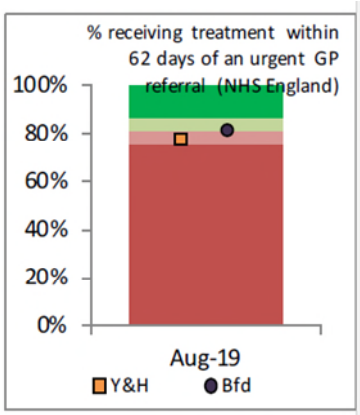


There were no benchmarks in those categories for the trust to compare itself to.

Performance for the cancer two week wait had reduced in August 2019 to 92.1%. it was projected at 94.1% in September 2019. Reduced capacity in the endoscopy department impacted on reduced performance. The trust performance was marginally below the average for the region, as indicated below.



Performance for the cancer 62 days to first treatment standard for August 2019 was 81.3% and forecast to remain below the standard for September 2019. This was below the 85% target for patients beginning their first treatment following an urgent GP referral for suspected cancer.



Leaders told us of improvement work to reduce waiting times for patients. Trust performance was slightly better in this category then the average for the area.
(see graph above).

There was some inconsistency in processes for managing risk, issues and performance in maternity services. The trust wide integrated dashboard did not contain any information about performance in maternity services. We asked some executives and NEDs about objectives and performance/safety indicators related to this area, and they were not able to tell us. They were not aware of some issues related to maternity such as the very high stillbirth rate, or low percentages of one to one care in labour. The design of the environment and ventilation equipment in maternity theatres did not adhere to national guidance, and the service did not monitor or control infection risks in theatres consistently well.
We reviewed board papers for the six months before our inspection, (papers from July, September

and November board meetings), and the only reference to maternity services was related to staffing or the maternity incentive scheme. We were not assured of the quality of care in this area.

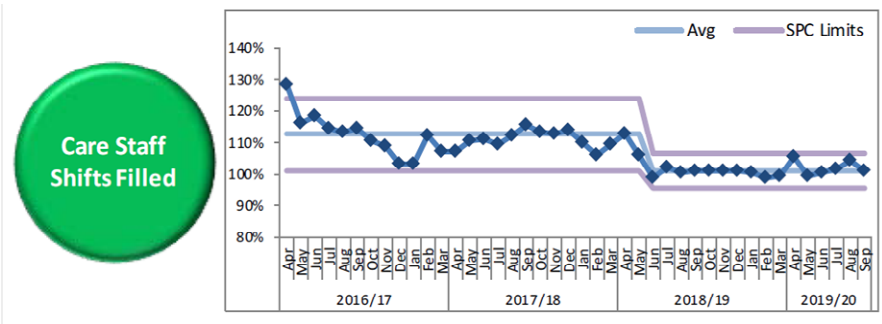
Staffing

The trust completed an annual strategic staffing review including all nursing areas. This was reported to the trust board. Since mid-2019, the nurse staffing was reported on a six-monthly basis. The review takes place with the Chief Nurse and nursing leaders in each area, taking account of NICE/NQB guidance, area specific guidance, quality and safety metrics, professional judgement, benchmarking data, patient and staff feedback/experience and other roles supporting the care in the environment.

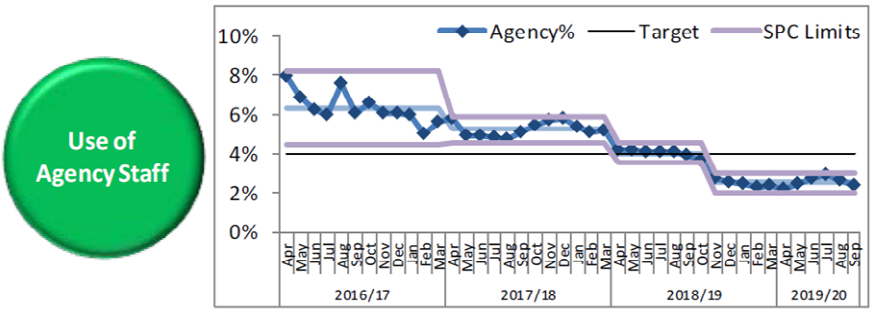
In addition, a monthly nurse staffing report was presented to the workforce committee and quality committee. The report contained a 'heat map' of in-patient wards showing other quality and safety metrics which could be affected by staffing numbers.

To mitigate against national challenges around nurse vacancies, the trust used other roles in clinical areas such as pharmacy technicians on wards and nursing associates. Where there were areas of concern measures to mitigate risk were agreed and support provided as far as possible.

The integrated dashboard of September 2019 indicated staffing fill rates were consistently 100%, as in the graph below.



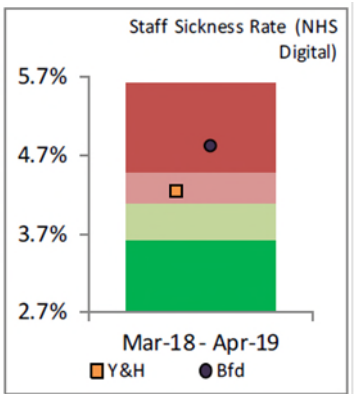
The trust had done work to reduce the use of agency staff. There had been an overall continued reduction in agency staff use across the last year, as in the graph below.



Reduction in the spending on agency staff had reduced by 44 % since 2016 (from £19 million to £10.6 million). Administrative and clerical agency staff use had reduced to 0.51 full time equivalent. Agency use across the medical and dental staff group had remained static in the last reporting period; as has the use of Allied Health Professionals (AHP's).

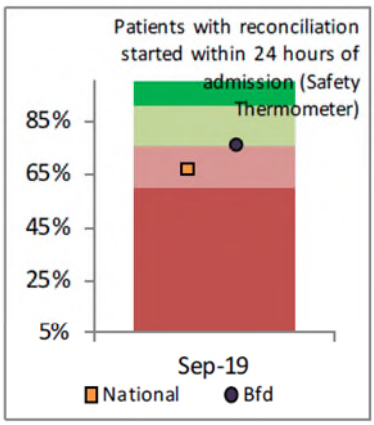
Staff turnover had decreased marginally at trust level in September 2019 by 0.03% to 10.7% from the previous month/ August 2019.

The 12-month sickness absence rate at the end of September 2019 was 4.8% against the trust of 4.5%. This was slightly higher than the average for Yorkshire and Humber, as in the graph below.



Medicines

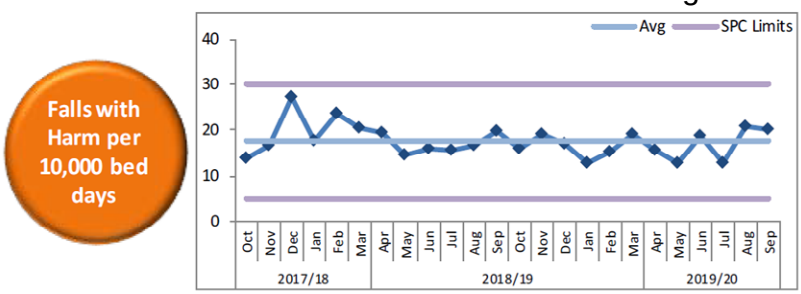
The trust used a monthly medicines safety thermometer which showed the medicines reconciliation rates were consistently higher than average. (Medicines reconciliation on hospital admission is to ensure that medicines prescribed on admission correspond to those that the patient was taking before admission). The graph below shows around 75% were started within 24 hours of admission.



Safety issues

The four types of patient safety incidents most frequently reported in the 12-month period from 1st July 2018 to 30th June 2019 were;

- Blood transfusion issues; Most blood transfusion related incidents related to procedural issues, such as incomplete or inaccurate details on samples and request cards. Some patients needed further venepuncture (to obtain a sample which does meet labelling requirements), which the trust classified as low harm.
- Patient falls; Most falls resulted in no harm or low harm. Every situation where a fall resulted in a fracture or serious head injury was subject to a root cause analysis (RCA), which was presented and analysed at the falls meeting. Learning from falls incidents was communicated to the clinical areas via the matrons and nursing networks. The percentage of falls with harm at the trust was better than the regional average.



- Medication; Most incidents related to medicines were about administration of medications. The medicines safety group monitored trends and themes and ensured that appropriate alerts were shared. There was a dedicated medicines safety officer who supported improvement and learning.

- Communication; there were a broad range of communication issues. The trust launched communication standards in 2019. This included learning from incidents related to communication, and monitoring issues related to missed patient appointments.

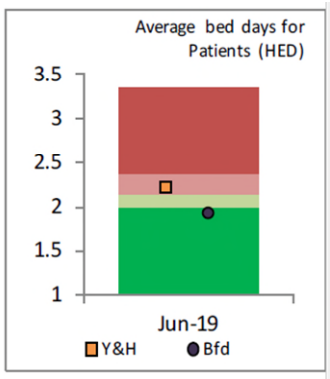
(Source; PIR- P28)

Audit

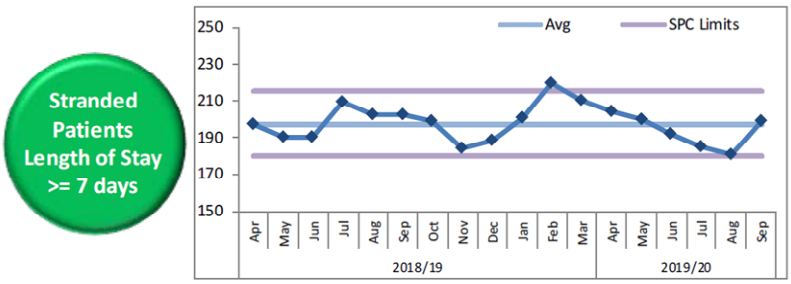
The trust participated in a wide range of national, regional and local audits. Clinical audit was used to find out if care was being provided in line with standards, to build on success and to make improvements where concerns were identified. For example, the national audit for care at the end of life showed positive results for the trust having excellent practice for 43% of patients at the end of their life. The audit also showed issues in communication and involvement in decision making, so the trust put several plans in place to address those issues.

Length of stay and delayed transfers of care

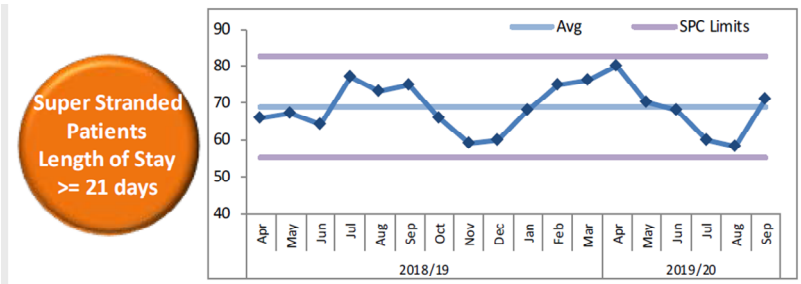
The trust performed well compared to regional and national averages for both elective and non-elective length of stay. The graph below shows the average length of stay at the trust in June 2019.



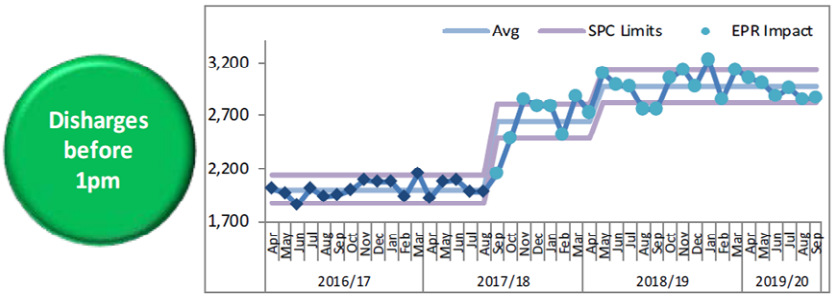
The trust measured the length of stay for patients who were not able to be discharged from hospital even though they were medically fit to leave. This impacted upon bed availability for acutely ill patients who needed to be admitted. The graph below shows the trend of 'stranded' patients over the last two years who had lengths of stay more than seven days.



There was a multi-agency integrated discharge team (MAIDT) made up of health and social care professionals and members of the voluntary sector. They worked together to support the safe discharge of people with complex needs. The trust also measured the lengths of stay for 'super stranded' patients who had been in hospital more than 21 days. The graph below shows the numbers of patients and the variability over time.



Following the implementation of the electronic patient record at the trust, the numbers of patient discharges earlier in the day (to make beds available) had steadily increased and improved. However, since April 2019, the trend was one of decreasing numbers of earlier discharges as seen in the graph below.



Information management

The board and committees received large amounts of detailed information to support their decision making. We saw that quality and sustainability were viewed on an equal basis. The integrated dashboard considered performance measures and information from across the trust, except for maternity services. This caused us concern as this meant there was not a holistic understanding of performance and safety information which could be discussed and acted on at board level.

Other information used in reporting, performance management or related to quality of care was usually accurate, reliable and relevant.

We met with a group of non-executive directors during our inspection. We were not assured that they were always able to challenge information or process it in committees before it went to the board, due to the volume of information.

Before our inspection, the trust sent us information as requested, relating to data quality. We were told data quality was vital and supported improved decision making, for improved patient care. Data quality at the trust applied to all areas including front line patient care, quality improvement, governance and trust management. We saw the integrated dashboard used a data quality 'kite mark' in the form of RAG ratings (red, amber, green) for assurance of information of seven domains;

- timeliness
- audit
- reliability
- relevance
- granularity
- validation
- completeness.

There was a data quality score ranging from 1-5 attributed to each of the indicators on the integrated dashboard related to assurance of the data. For example, the range of scores went from a score of 1 indicated insufficient systems, processes or documentation available to provide assurance, to 5 which meant there were full systems, processes and documentation available and the data had been independently verified with full assurance provided.

The table below shows three examples of the data indicator and the quality score;

Indicator	Definition	Data quality score
Sepsis Patients Screened	Percentage of patients screened for Sepsis	5.0

Bed Occupancy	Average percentage of available beds which were occupied overnight.	2.3
Elective Day Case Rate	The number of patients admitted for planned procedure and leave same day as a % of all procedures.	1.0

(Source: Integrated dashboard)

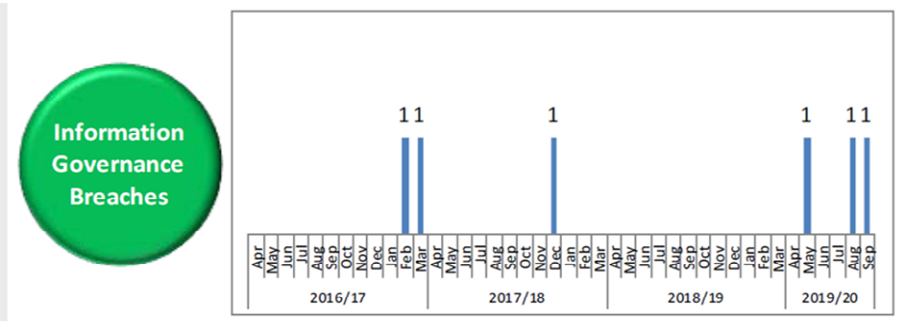
The trust had a data governance group, membership included data owners across the trust. The group was supported by a data quality dashboard with defined key performance indicators (KPIs). The focus of the group was to increase understanding and accountability for data quality and governing the trust's critical data.

There was a data quality framework and an associated data quality improvement plan which was refreshed on an annual basis, by the data governance group. This group reported into the information governance sub-committee, which reported to the quality committee.

The data quality framework set out controls and assurance mechanisms that were in place, and gaps and improvement plans. An annual data audit and maturity assessment were managed by the informatics data quality team.

The medical director was the trust's Caldicott guardian. A Caldicott guardian is a senior person within an organisation who makes sure that personal information about those who use its services is used legally, ethically and appropriately, and that confidentiality is maintained.

Information governance is the way the trust handles and processes information. It covers personal data (relating to patients and employees) and corporate information (such as financial and accounting records). The graph below from the integrated dashboard shows the trust reported were three information governance breaches in 2019.



The data security and performance (DSP) toolkit is a national performance tool produced by NHS Digital which draws together the legal rules and central guidance surrounding data protection and presents them as a set of information governance standards. The trust is required to carry out a yearly self-assessment of compliance against these standards. The results of the latest self-assessment of 2018/19 was that standards were met.

The trust had moved to an electronic patient record (EPR) in September 2017. We met with the chief digital information officer and the chief clinical information officer. They told us EPR was used in most settings within the hospital; inpatient, outpatient and community. As EPR was an administration and clinical system, this meant information such as patient demographics and future appointments was visible alongside patient observations and clinical documentation. Access to critical patient information such as drugs and allergies was available all the time. If a patient deteriorated and a clinician is not locally available, they could access the patient record to aid

decision making and prescribe medication.

If the EPR record became unavailable, there was access to the primary care record system which held clinical data about patients including all letters and discharge summaries. There were some weaknesses in the EPR system. Although interfaces across other systems were in place, staff needed to use some specialist systems. ECGs and endoscopy reports were not available in the EPR and some paper records needed to be scanned onto the system such as anaesthetic records and consent forms. The trust continued to review the integrity of medical records; there was a group chaired by a consultant medical information officer, who assessed and reported on the risk of non-electronic records.

The trust had invested in a command centre, which drew information in real time from a range of sources including EPR and was used to support clinical and operational decision making. The centre had a range of large video monitors staff to follow and act on the information. There was information about patients, available beds, diagnostics, and other factors that impacted on patient care and their 'flow' through the hospital. This gave a clear understanding of current and predicted pressures.

Engagement

A range of people's views and concerns was encouraged and acted on. We saw that senior leaders proactively engaged with staff, people who used services and external partners and stakeholders. A programme of board visits had begun where leaders went to clinical areas to meet with staff. Governors told us they were no longer part of the board walkabouts to meet with staff. They had been working as part of a 'task and finish' group to try improving communication and engagement.

The latest staff survey showed an improvement in staff engagement from the year before. The trust scored 7.2 for engagement, compared to an average of 7, and where the best national score was 7.6. Front line staff we spoke with told us leaders were visible and approachable; staff felt they could openly talk to senior leaders and managers. Leaders told us staff engagement and morale were above average however they were aware there was more to do to improve staff experience.

There had been an initiative know as 'work as one' to engage with staff and help shape the culture. Events from the initiative brought people together to make improvements. Leaders told us the challenge was to embed and sustain the changes; engaging with all staff groups to make sure all staff had a positive experience at work.

The "let's talk" programme started in 2017 and was a programme of staff engagement on having effective conversations. It included;

- Let's Talk: the unifying theme for all internal engagement, and a weekly chief executive newsletter
- Let's Talk: Live- informal staff groups to meet the chief executive and other executives
- Let's Talk About Us: staff-led groups to discuss the trust values
- Let's Talk Together; quarterly senior leaders' timeout sessions
- Let's Celebrate; monthly and annual staff awards
- Let's Talk Hub: one stop intranet site for key resources
- Time2Talk: simplified appraisal process, focus on regular conversation

Is there a patient engagement group?? What were they involved in and how had it shaped services?

The trust routinely engaged with local commissioners, NHS England/ improvement and local GPs.t.

Feedback from stakeholders we spoke with demonstrated there was positive engagement from the trust. The trust had developed a stakeholder engagement framework to support improved engagement with the stakeholders. It aimed to strengthen the overall corporate governance. Perceived benefits were that this would help build stronger relationships and help the trust consolidate intelligence held throughout the trust. There were four strands to the framework;

- Mapping the stakeholders: A mapping exercise showed the trust has around 80 significant external relationships, some of which were transactional and needed less direct engagement. The list of relationships being managed was reviewed by the board's partnerships committee, executive management team and the board.
- Sponsoring stakeholders: Executive directors 'sponsored' their own portfolio of stakeholders so there was active executive contact and oversight. The chief executive had oversight of all the stakeholders and sponsorships.
- Account Management: there was a trust account manager for each stakeholder. The account manager reported to the executive director. Each six months a stakeholder report was sent to the service and business development team. Progress against any actions were monitored by the partnerships committee and improvements made; best practice was then shared across all sponsors and account managers.
- Gaining feedback from stakeholders: the trust gained feedback from stakeholders to identify any areas for improvement within the engagement. There was an annual stakeholder engagement survey which stakeholders found positive to take part in.

The trust was part of a collaborative of five regional acute trusts, known as WYATT (West Yorkshire association of acute trusts). The aim was to develop and build on West Yorkshire-wide solutions and models of care. There was particularly close work and engagement with a neighbouring trust, to collaborate on service delivery for patients. There were joint programme management posts in place and a joint clinical summit was held in April 2019. This resulted in a comprehensive programme of clinically led work to create shared services across the two trusts. The engagement and joint working resulted in the development of integrated models of care particularly around diabetes, one of the most prevalent diseases in Bradford.

Learning, continuous improvement and innovation

There was a good focus on learning and improvement throughout the trust and we saw appropriate use of participation in research. There was knowledge of improvement methods, and there were systems in place to support innovation and improvement work.

One of the trusts strategic objectives was to be a continually continually learning organisation. We were told of several approaches to learning, sustainable quality improvement and innovation.

The improvement approach was based on the NHS Improvement sponsored 'quality, service improvement and redesign' principles. This meant the trust used those principles to deliver what was known as sustainable quality improvement (SQI). This was underpinned by the SQI training plan, targeted at all levels across the organisation and was supported by the SQI toolkit and a variety of tailored training packages and standardised improvement tools.

Before our inspection, the trust sent us information about the Bradford improvement programme 2019-2020. This provided structure, supported by systems and training so staff could explore new ways to deliver better patient outcomes. There were four key improvement programmes;

- Safety and reliability of care

- Value and efficiency
- Workforce,
- Urgent Care; this was supported by two further enabling programmes, the analytics hospital group and the going digital group

The trust worked in collaboration locally, regionally and nationally regarding learning and improvement. For example, they worked closely with the Improvement Academy, which works across Yorkshire and Humberside. There was active engagement with the Bradford Institute for Healthcare Research, and the Wolfson Centre for research was on site. There was proactive work with NHS QUEST, a national network for NHS trusts to focus on improving quality and safety. Examples of such work included improvements in patient flow and safety in theatres.

We were told about 'work as one', weeks, where frontline staff were encouraged to work on positive changes to create continuous improvements. The local commissioners and local authority took part in one of the weeks to improve patient experiences in moving from hospital to the community.

The trust was a partner in Bradford's community partnership model. It was involved in 10 community partnerships working with local partners and a range of health and social care providers, including the voluntary sector, to support the health and well-being of local communities of around 60,000 people.

'Well Bradford' was an innovative programme led by the trust aimed at helping local communities live healthier lives. It focussed on three specific communities in Girlington, Holme Wood and Keighley. The aim of the programme was to transform neighbourhoods into dynamic communities where local people lived and worked. The programme was led by the trust on behalf of Bradford's integration and change board and had close connections with 'Born in Bradford' research, which links social circumstance and behaviour to health outcomes and wellbeing. Well Bradford had created some green spaces, so communities had a focal area. Examples included turning derelict ground into a community garden, planting more trees, and holding clean air and family fun days.

A significant proportion of the local population were of south Asian heritage with a risk up to four times the usual risk of developing type 2 diabetes. The trust dietitians led an innovative range of structured education programmes for diabetes across the city. This was designed to be culturally appropriate. There were programmes for low carbohydrate diets and reversing diabetes, weight management programmes for individuals or groups.

The trust took part in a national innovative pre-employment programme called 'project search' to help young people with learning difficulties gain the skills they needed to get meaningful paid jobs. The trust had an equality objective to directly employ a third of 'interns' following their graduation which we saw had been met. The trust won an award from the local university in 2018 in recognition of "outstanding work in healthcare human resource management".

The informatics team had been shortlisted for two awards and won the national digital health team of the year award in July 2019.

The trust had won the Health Service Journal national patient safety award in 2019 for innovation of the year. It started a project that used art and drawing to distribute effective healthcare communication, especially for patients whose first language was not English. There had been other innovations. The children and young people's team had also won a Health Service Journal award in the emergency care category, for bringing care to young patients in their own home, this avoiding unnecessary hospital admission.

The safeguarding children team had developed a standard operating procedure linked to termination of pregnancy, for assisting the police in the capturing of evidence in cases of suspected child sexual assault. This meant that there was irrefutable DNA evidence to enable prosecution,

sparing the victims the additional trauma of having to give evidence in court. For this, the team were awarded a West Yorkshire Police Chief Officer commendation and were a finalist in the West Yorkshire Police force awards for protecting vulnerable victims. The work around this had been shared regionally and nationally.

Complaints process overview

The trust was asked to comment on their targets for responding to complaints and current performance against these targets for the last 12 months.

Question	In days	Current performance
What is your internal target for responding to complaints?	3	100%
What is your target for completing a complaint	30 working days or a timescale agreed with the complainant up to 6 months	100%
If you have a slightly longer target for complex complaints please indicate what that is here	30 working days or a timescale agreed with the complainant up to 6 months	100%
Number of complaints resolved without formal process in the last 12 months?	164 complaints that did not require a formal response plus 1,300 PAL's where issues raised were resolved and did not require formal complaint at complainants request. Total =1,464 (August 2018 – July 2019)	

(Source: Routine Provider Information Request (RPIR) – Complaints Process Overview tab)

Number of complaints made to the trust

From August 2018 to August 2019, the trust received a total of 523 complaints. The highest number of complaints were for medicine, with 31.9% of total complaints, followed by surgery (26.2% of complaints) and urgent and emergency services (13.2%).

Core Service	Number of complaints	Percentage of total
Medical care	167	31.9%
Surgery	137	26.2%
Urgent and emergency services	69	13.2%
Outpatients	54	10.3%
Maternity	29	5.5%
Services for children and young people	16	3.1%
Other	17	3.3%
Gynaecology	13	2.5%
Diagnostics	12	2.3%
Critical care	4	0.8%
End of life care	2	0.4%
Provider wide	2	0.4%
CHS - Children, young people and families	1	0.2%
Total	**523**	**100.0%**

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Compliments

From August 2018 to August 2019, the trust received a total of 981 compliments. The highest

number of compliments were for surgery, with 70.1% of total compliments, followed by medicine (24.4% of compliments) followed by outpatients (1.7%).

A breakdown by core service can be seen in the table below:

Core service	Number of compliments	Percentage of total
Surgery	688	70.1%
Medical care	239	24.4%
Outpatients	17	1.7%
Services for children and young people	13	1.3%
Other	8	0.8%
Urgent and emergency services	5	0.5%
Diagnostics	3	0.3%
Adults Community	3	0.3%
Critical Care	2	0.2%
Maternity	2	0.2%
Gynaecology	1	0.1%
End of life care	0	0.0%
Total	**981**	**100.0%**

(Source: Routine Provider Information Request (RPIR) – Compliments)

Serious incident Process Overview

Need to know how many SIs we looked at and what the findings were

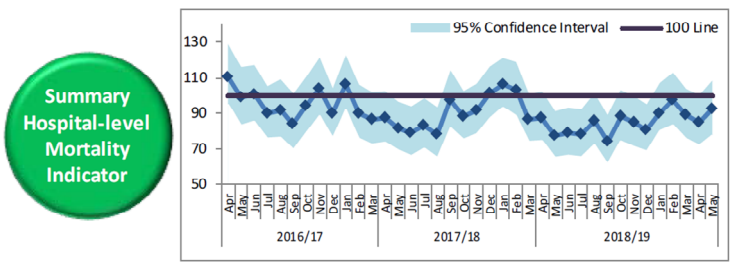
Mortality, Learning from deaths

We met with the chief medical officer who was the executive lead for mortality. We also met with another consultant who had been instrumental in setting up the trust's mortality review process. We reviewed ???? reviews carried out after patients had died.

Since April 2017, the national 'learning from deaths' framework has stipulated that trusts must collect and publish, via quarterly public board papers, information related to deaths of patients.

There are two main measures used nationally; the hospital standardised mortality ratio (HSMR) and the summary hospital level mortality indicator (SHMI). The HSMR is worked out according to observed deaths divided by expected deaths, multiplied by 100. A score of 100 means that the number of deaths is similar to what would be expected. A higher score means more deaths; a lower score, means fewer. The most recent mortality data at the trust (April 2018 - March 2019) showed the HSMR was 92.

The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die based on average England figures, given the characteristics of the patients treated. The latest SHMI at the trust was 91, which was 'better than expected'. The graph below shows the trends over the last three years.



Senior leaders told us all patient deaths were screened on a weekly basis. If an unexpected death was suspected through routine case note review, a second reviewer was assigned from another speciality. If the death is still thought to be unexpected, the patients care is referred to the risk department and the quality of care panel decided if further investigation was needed. If any deaths were identified which needed further review or investigation, a structured judgement review (SJR) was carried out against the national criteria set out in the learning from deaths guidance (2017). The reviews are carried out by trained reviewers using the SJR methodology.

The findings of the SJRs were reviewed at specialty level and any areas of good practice, local improvement or risk were identified. In addition, all reviews were centrally collated and analysed at a speciality level. A report of completed SJRs along with their associated learning was presented at the mortality sub-committee. Quarterly reports were also submitted to the quality committee.

Accreditations

NHS trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The table below shows which of the trust's services have been awarded an accreditation.

Accreditation scheme name	Service accredited
Accreditation from the British Society of Urogynaecology	The Urogynaecology Unit has accreditation by the British Society of Urogynaecology, one of the first centres in the UK to be accredited.
ISO 9000 - Radiation Physics	Radiation Physics is ISO9001:2015 accredited.
ISO 9000 - Estates Project Management	Successful accreditation and assimilation to new ISO 9001 - 2015 standard, capital projects section (complete 2017).
QISMET quality accreditation	Diabetes Insulin Carbohydrate Education (DICE) range of Diabetes Structured Education programmes delivered for T1 and T2 in hospital and across district achieved full Quality Institute for Self-Management Education and Training (QISMET) quality accreditation in April 2019.
The Pennine Breast Screening Unit operate under ISO international standards	Successful accreditation under ISO9001:2015.
ISO 9000 - Medical Illustration	Successful accreditation under ISO9001:2015.
ISO9001:2015 - Clinical Engineering	Clinical Engineering holds ISO9001:2015 certification for the maintenance and service of medical equipment.
UNICEF Baby friendly Initiative neonatal standards	The neonatal unit was accredited with United Nations Children's Fund (UNICEF) baby friendly Initiative neonatal standards in Dec 2017.
Safe Effective Quality Occupational Health	The Occupational Health Service were

Standards (SEQOHS) Accreditation	awarded Safe Effective Quality Occupational Health Service (SEQOHS) accreditation in July 2019.
British Parking Association Safer Parking Scheme (Park Mark Award).	Smith Lane Car Park Accessible Entrance Car Park Duckworth Lane Car Park Main Entrance Car Park Horton Wing P&D Car Park C Block Car Park

(Source: Routine Provider Information Request (RPIR) – Accreditations tab).

Acute services

Bradford Royal Infirmary

Ducksworth Lane
Bradford
BD9 6RJ

Tel: 01274 542200

www.bradfordhospitals.nhs.uk/our-hospitals/bradford-royal-infirmary-bri/

Medical care (including older people's care)

Facts and data about this service

Medical care, including care of the elderly services is provided within the unplanned care group. The following clinical business units are included within the unplanned care group:

- Urgent and emergency care
- Elderly and intermediate care
- Digestive diseases and general surgery
- Specialist medicine
- Radiology and imaging
- Haematology, cancer and palliative care
- Therapies

The unplanned care group provides acute care across two hospital sites in the city of Bradford:

- Bradford Royal Infirmary
- St Luke's Hospital

Unplanned care group wards at Bradford Royal Infirmary have the following beds:

- Ward 1 AMU - 22 beds
- Ward 3 Elderly – 25 beds
- Ward 4 AMU – 22 beds
- Ward 6 Stroke – 29 beds (including Hyper Acute Stroke Unit)
- Ward 17 Cardiology – 18 beds
- Ward 23 Respiratory – 20 beds
- Ward 29 Elderly – 30 beds
- Ward 31 Elderly – 29 beds
- Ward 33 Clinical Haematology – 12 EnSite beds

Unplanned care group wards at St Luke's Hospital have the following beds:

- F5 Intermediate Care – 27 beds
- F6 Intermediate Care – 24 beds

The elderly and intermediate care service in Bradford provides services to the older population of the region.

The trust offers a consultant-led service for people over the age of 77 who are acutely unwell. Patients are usually admitted via accident and emergency or by their GP. These wards include:

- Ward 3 – admissions and assessment. Patients are admitted to this ward for assessment before being discharged or moved to a ward equipped for a longer spell of care.
- Ward 29 – acute care of the elderly. Patients are moved to these wards if they need a longer period of acute consultant-led care.
- Ward 31 – acute admissions unit for neck of femur and acute elderly care.

The elderly virtual ward has been established as an enabling multi-disciplinary team to support older people at home. It has been a step-down and step-up model with a 'discharge to assess' mentality linked to the trust's older people assessment unit and offering comprehensive geriatric assessment to all patients, with a view to preventing admissions from primary care.

The haematology team provide a comprehensive service for the diagnosis and treatment of malignant and non-malignant disorders of the blood and bone marrow. The inpatient care is provided on Ward 33 accommodating 12 single side rooms. The care is delivered by a ward manager, junior sister, eight qualified nurses, six health care assistants (HCA's) and a team of volunteers.

The therapies clinical business unit provides the following services: dietetics, physiotherapy, occupational therapy and psychology.

(Source: Routine Provider Information Request AC1 - Acute context)

From March 2018 to February 2019, the trust had 51,826 medical admissions. Emergency admissions accounted for 27,042 (52.2%), 600 (1.2%) were elective, and the remaining 24,184 (46.7%) were day case.

Admissions for the top three medical specialties were:

- General medicine: 14,122
- Gastroenterology: 12,358
- Geriatric medicine: 6,875

(Source: Hospital Episode Statistics)

Is the service safe?

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone

completed it.

Staff were required to complete a number of mandatory training modules which included basic life support, infection control, conflict resolution, safeguarding, information governance and equality and diversity. Training was either face to face or e-learning, depending on the topic.

All staff we spoke with said they were up to date with their mandatory training or had booked onto any outstanding training. Staff told us they received an email when they were due to complete mandatory training and they were encouraged to book on by their line manager. Staff were able to access their training records on an electronic system.

Senior ward sisters kept records of nursing staff compliance with mandatory training and were clear on what training individual staff needed to complete to keep up to date. They were positive about the levels of mandatory training for their ward staff. For example, the overall mandatory training level for nursing staff on ward 1 (acute medical unit) for October 2019 was 95%, ward 6 (stroke and neurology) 93%, cardiology 95% and ward 3 (elderly care assessment unit) 95.4%.

Staff did not receive specific mandatory training to enable them to care for people with a mental health problem or a learning disability. Staff consistently told us that they referred to the psychiatric liaison service for support with mental healthcare.

Mandatory training completion rates

The trust set two different targets of 85% and 95% for completion of mandatory training. These targets were dependant on individual modules.

Trust level

A breakdown of compliance for mandatory training courses April 2018 to March 2019 at trust level for qualified nursing staff in medicine is shown below:

Training module name	April 2018 to March 2019				
	Eligible staff	Staff trained	Completion rate	Trust target	Met (Yes/No)
Mental Capacity Act Level 1	217	217	100.0%	85%	Yes
Corporate Induction	230	230	100.0%	85%	Yes
Infection Control - No Renewal	230	230	100.0%	85%	Yes
Mental Capacity Act Level 2	219	206	94.1%	85%	Yes
Introduction to Equality & Diversity General	230	215	93.5%	85%	Yes
Communication Improvement using the SBAR Technique General	216	201	93.1%	85%	Yes
Diabetes Care and Safe Use of Insulin General	151	135	89.4%	85%	Yes
Safe Administration of Medicines - 2 Year	203	172	84.7%	85%	No
Information Governance - 1 Year	230	180	78.3%	95%	No
Infection Control - 1 Year	230	173	75.2%	85%	No
Venous Thromboembolism - No Renewal	147	108	73.5%	85%	No
Safe Administration of Medicines - Competence Assessment General	64	47	73.4%	85%	No
Conflict Resolution - 3 Years	211	153	72.5%	85%	No
Blood Transfusion - 2 Years	121	86	71.1%	85%	No
Adult Basic Life Support - 1 Year	218	148	67.9%	85%	No
Collecting Blood Competency	119	78	65.5%	85%	No

Assessment & Theory - 2 Year					
Naso Gastric (NG) Tube Care & Administration General	24	13	54.2%	85%	No
Preparing to Administer/Administering Blood - 3 Year	119	62	52.1%	85%	No
Organising Receipt of Blood - 3 Year	119	58	48.7%	85%	No
Moving & Handling Medium/High Risk General	139	53	38.1%	85%	No

In medicine the 95% target was not met for the single applicable training module. The 85% target was met for seven of the remaining 19 mandatory training modules for which qualified nursing staff were eligible.

A breakdown of compliance for mandatory training courses from April 2018 to March 2019 at trust level for medical staff in medicine is shown below:

Training module name	April 2018 to March 2019				
	Eligible staff	Staff trained	Completion rate	Trust target	Met (Yes/No)
Naso Gastric (NG) Tube Placement Self Certification General	15	15	100.0%	85%	Yes
Dangers of Misplaced Naso Gastric (NG) Tube (NPSA Alert)General	6	6	100.0%	85%	Yes
Infection Control - No Renewal	120	119	99.2%	85%	Yes
Mental Capacity Act Level 1	65	64	98.5%	85%	Yes
Corporate Induction	120	117	97.5%	85%	Yes
Introduction to Equality & Diversity General	120	117	97.5%	85%	Yes
Acute Kidney Injury (AKI)General	76	72	94.7%	85%	Yes
Diabetes Care and Safe Use of Insulin General	72	68	94.4%	85%	Yes
Safe Administration and Preparation of Injectables General	78	73	93.6%	85%	Yes
Communication Improvement using the SBAR Technique General	76	71	93.4%	85%	Yes
Mental Capacity Act Level 2	66	60	90.9%	85%	Yes
Preparing to Administer/Administering Blood - 3 Year	10	9	90.0%	85%	Yes
Information Governance - 1 Year	120	97	80.8%	95%	No
Blood Transfusion - 2 Years	57	43	75.4%	85%	No
Infection Control - 1 Year	78	57	73.1%	85%	No
Adult Basic Life Support - 1 Year	76	42	55.3%	85%	No

In medicine the 95% target was not met for the single applicable training module. The 85% target was met for 12 of the remaining 15 mandatory training modules for which medical staff were eligible.

Bradford Royal Infirmary medicine department

The trust set two different targets of 85% and 95% for completion of mandatory training. These targets were dependant on individual modules.

A breakdown of compliance for mandatory training courses April 2018 to March 2019 at Bradford Royal Infirmary for qualified nursing staff in medicine is shown below:

Training module name	April 2018 to March 2019				
	Eligible staff	Staff trained	Completion rate	Trust target	Met (Yes/No)
Mental Capacity Act Level 1	160	160	100.0%	85%	Yes
Corporate Induction	171	171	100.0%	85%	Yes
Infection Control - No Renewal	171	171	100.0%	85%	Yes
Introduction to Equality & Diversity General	171	160	93.6%	85%	Yes
Mental Capacity Act Level 2	163	152	93.3%	85%	Yes
Communication Improvement using the SBAR Technique General	161	150	93.2%	85%	Yes
Diabetes Care and Safe Use of Insulin General	105	93	88.6%	85%	Yes
Safe Administration of Medicines - 2 Year	148	125	84.5%	85%	No
Information Governance - 1 Year	171	140	81.9%	95%	No
Safe Administration of Medicines - Competence Assessment General	59	44	74.6%	85%	No
Infection Control - 1 Year	171	127	74.3%	85%	No
Conflict Resolution - 3 Years	157	110	70.1%	85%	No
Blood Transfusion - 2 Years	92	63	68.5%	85%	No
Venous Thromboembolism - No Renewal	102	69	67.6%	85%	No
Adult Basic Life Support - 1 Year	161	103	64.0%	85%	No
Collecting Blood Competency Assessment & Theory - 2 Year	91	56	61.5%	85%	No
Naso Gastric (NG) Tube Care & Administration General	24	13	54.2%	85%	No
Preparing to Administer/Administering Blood - 3 Year	91	42	46.2%	85%	No
Moving & Handling Medium/High Risk General	103	47	45.6%	85%	No
Organising Receipt of Blood - 3 Year	91	37	40.7%	85%	No

In medicine the 95% target was not met for the single applicable training module. The 85% target was met for seven of the remaining 19 mandatory training modules for which qualified nursing staff were eligible.

A breakdown of compliance for mandatory training courses from April 2018 to March 2019 at Bradford Royal Infirmary for medical staff in medicine is shown below:

Training module name	April 2018 to March 2019				
	Eligible staff	Staff trained	Completion rate	Trust target	Met (Yes/No)
Dangers of Misplaced Naso Gastric (NG) Tube (NPSA Alert)General	5	5	100.0%	85%	Yes
Naso Gastric (NG) Tube Placement	15	15	100.0%	85%	Yes

Self Certification General					
Infection Control - No Renewal	101	101	100.0%	85%	Yes
Mental Capacity Act Level 1	53	53	100.0%	85%	Yes
Introduction to Equality & Diversity General	101	100	99.0%	85%	Yes
Corporate Induction	101	99	98.0%	85%	Yes
Acute Kidney Injury (AKI)General	63	61	96.8%	85%	Yes
Safe Administration and Preparation of Injectables General	65	62	95.4%	85%	Yes
Diabetes Care and Safe Use of Insulin General	63	60	95.2%	85%	Yes
Communication Improvement using the SBAR Technique General	63	60	95.2%	85%	Yes
Mental Capacity Act Level 2	53	49	92.5%	85%	Yes
Preparing to Administer/Administering Blood - 3 Year	10	9	90.0%	85%	Yes
Information Governance - 1 Year	101	79	78.2%	95%	No
Blood Transfusion - 2 Years	48	34	70.8%	85%	No
Infection Control - 1 Year	65	46	70.8%	85%	No
Adult Basic Life Support - 1 Year	63	34	54.0%	85%	No

In medicine the 95% target was not met for the single applicable training module. The 85% target was met for 12 of the remaining 15 mandatory training modules for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Safeguarding

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

Staff had a good knowledge and understanding of the trusts safeguarding policies and their role and responsibilities in relation to protecting patients from abuse. Staff could give examples of what constituted a safeguarding concern and how they could raise an alert. Staff gave examples of safeguarding referrals they had made and alerts they had raised in relation to vulnerable adults and children.

The chief nurse was the executive lead for safeguarding and was supported in their duties by the deputy chief nurse who was the operational lead. There was a safeguarding adult lead nurse and safeguarding children lead nurse who were available to offer advice and support to staff on safeguarding matters.

From 1 August 2018 to 31 July 2019 staff in medical care services made 320 adult safeguarding referrals and six child safeguarding referrals.

(Source: Routine Provider Information Request (RPIR) – safeguarding refs tab)

The trust set a target of 85% for completion of safeguarding training.

Trust level

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 at

trust level for qualified nursing staff in medicine is shown below:

Training module name	April 2018 to March 2019				
	Eligible staff	Staff trained	Completion rate	Trust target	Met (Yes/No)
Safeguarding Children Level 1 - 3 Years	230	215	93.5%	85%	Yes
Safeguarding Adults Level 1 - 3 Years	230	214	93.0%	85%	Yes
Safeguarding Children Level 2 - 3 Years	230	202	87.8%	85%	Yes
Safeguarding Adults Level 2 - 3 Years	230	196	85.2%	85%	Yes

In medicine the 85% target was met for all safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 at trust level for medical staff in medicine is shown below:

Training module name	April 2018 to March 2019				
	Eligible staff	Staff trained	Completion rate	Trust target	Met (Yes/No)
Safeguarding Adults Level 2 - 3 Years	1	1	100.0%	85%	Yes
Safeguarding Children Level 1 - 3 Years	120	110	91.7%	85%	Yes
Safeguarding Children Level 2 - 3 Years	79	67	84.8%	85%	No
Safeguarding Adults Level 1 - 3 Years	120	96	80.0%	85%	No

In medicine the 85% target was met for two of the four safeguarding training modules for which qualified nursing staff were eligible.

Bradford Royal Infirmary medicine department

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 at Bradford Royal Infirmary for qualified nursing staff in medicine is shown below:

Training module name	April 2018 to March 2019				
	Eligible staff	Staff trained	Completion rate	Trust target	Met (Yes/No)
Safeguarding Adults Level 1 - 3 Years	171	160	93.6%	85%	Yes
Safeguarding Children Level 1 - 3 Years	171	158	92.4%	85%	Yes
Safeguarding Children Level 2 - 3 Years	171	147	86.0%	85%	Yes
Safeguarding Adults Level 2 - 3 Years	171	142	83.0%	85%	No

At Bradford Royal Infirmary's medicine department the 85% target was met for three of the four safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 at Bradford Royal Infirmary for medical staff in medicine is shown below:

Training module name	April 2018 to March 2019				
	Eligible	Staff	Completion	Trust	Met

	staff	trained	rate	target	(Yes/No)
Safeguarding Adults Level 2 - 3 Years	1	1	100.0%	85%	Yes
Safeguarding Children Level 1 - 3 Years	101	91	90.1%	85%	Yes
Safeguarding Children Level 2 - 3 Years	66	54	81.8%	85%	No
Safeguarding Adults Level 1 - 3 Years	101	80	79.2%	85%	No

At Bradford Royal Infirmary's medicine department the 85% target was met for two of the four safeguarding training modules for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Cleanliness, infection control and hygiene

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

We found that the environment was visibly clean, and that systems and processes were in place to control infection and promote hygiene.

Hand-washing facilities were available throughout all wards we visited. Personal protective equipment (PPE) including aprons and gloves, and sanitising hand gel were also available.

We saw staff using PPE when completing clinical tasks. They followed the bare below the elbows recommendations which met national best practice guidance, correct handwashing technique and use of sanitising hand gels was seen.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

Patients with infections were barrier nursed in side rooms and appropriate signage was in place on the door. Side rooms had a red/amber/green infection status displayed on the door, so staff understood what precautions to take on entering and exiting the room. There were two negative pressure isolation rooms on ward 31 (elderly care) which were used to accommodate patients showing symptoms of or diagnosed as having an airborne contagious disease. Staff wore yellow protective aprons when entering a room where risk of infection was present. This allowed staff to challenge any member of staff if they did not remove the apron when leaving the side room.

Arrangements were in place for those patients returning from holiday in high risk of infection regions. A trolley of equipment was available for patients suspected of having Middle East Respiratory Syndrome (MERS), although staff told us that a case had not yet been confirmed.

The service carried out regular infection prevention and control audits on medical wards. The audits included hand hygiene, dress code, catheter care and commode cleaning. The results were colour rated, green for scores of 90% to 100%, amber scores of 80% to 90% and red for scores below 80%. We saw that any areas scoring red had an action plan which identified actions to improve, including staff training.

Staff completed infection prevention and control training. For the period April 2018 to March 2019, compliance was 74.3% for nursing staff and 70.8% for medical staff at this hospital, which did not meet the trust target of 85%.

Environment and equipment

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

All wards we visited were tidy, well organised and visibly clean. Cleaning was in progress in the areas we visited with safety signage displayed.

All wards had daily safety checklists for the nurse in charge and for the health care assistant co-ordinator to complete. The checklists included checks on the environment and equipment such as sharps bins, resuscitation trollies and hoists. We saw they were completed on the wards we visited.

We checked 10 pieces of equipment which included, hoists, ultrasound and blood gas equipment, blood pressure monitors. We found they were in good working order and all had stickers to show they had been serviced within the last year and tested for electrical safety. All oxygen cylinders we checked were maintained and stored securely.

Resuscitation trollies were tagged to ensure they had not been tampered with or items removed. We saw they had been checked daily by staff on all wards we visited. A gastro-intestinal bleed trolley was available for staff to use in the endoscopy unit.

We saw that equipment for the management and prevention of pressure ulcers was available such as specialist mattresses and cushions and staff told us they could access bariatric equipment if this was needed for a patient.

There was a programme of environmental improvement for some wards. Ward 22 (cardiology and coronary care unit) was temporarily relocated to ward 17 whilst ward 22 was being refurbished. Staff told us they had planned the move carefully and worked together to ensure that services to patients were not disrupted. There was a relative's room and a patient's day room on ward 17.

Ward 23 (respiratory) was located above ward 22 and at times was very noisy due to the refurbishment works on the ward below. Patients told us that although it was noisy staff had apologised and explained to them that the noise was part of the ongoing work to improve the facilities for patients.

Staff disposed of clinical waste safely. Waste was appropriately segregated, and sharps bins were labelled and dated with temporary closures in place.

Assessing and responding to patient risk

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

Measures were in place to ensure that staff assessed and responded to patient risk. Nursing staff completed a range of patient risk assessments on admission to the hospital/ward. These included falls, moving and handling, nutrition and hydration and pressure damage risk. All patients were assessed for risk of Venous Thromboembolism (VTE) on admission.

The trust used an updated version of the National Early Warning Score (NEWS2) to measure whether a patient's condition was improving, stable or deteriorating indicating when a patient may require a higher level of care. NEWS2 had been rolled out to all wards in February 2019 and staff had received training. All registered nurses had been supplied with a laminated pocket size NEWS chart which provided guidance on when to escalate a patient for a medical review. Staff told us that doctors responded quickly when patients deteriorated, and the critical care outreach team were also available to respond between 7.30am and 6.30pm.

Staff recorded patient observations in the patient's electronic record. The record system was also configured to alert for the risk of sepsis. The sepsis alert was automatically triggered when a patient's observations and biochemical parameters triggered the agreed criteria. When this occurred a sepsis risk was flagged on the patient's electronic record on the front screen and staff were required to take action to move to the next screen. Patients with chronic respiratory disease were set individual parameters for escalation according to their condition.

The trust had appointed a sepsis nurse in October 2018 who had rolled out a series of improvements. This included staff training, developing standard protocols and the establishment of a deteriorating patient group. We saw information on the cause, symptoms and treatment of sepsis was displayed on the notice boards on wards.

The trust audited the use of local physiological track and trigger systems including NEWS2 and sepsis. Results showed an improvement from the previous year in patient observations recorded within one hour of arrival to the emergency department and or direct admission to ward area (95.2% in 2019 compared to 83% in 2019). The audit found that the escalation and timely medical review of the deteriorating patient was an area for improvement and the deteriorating patient group had commenced a quality improvement project to focus on this.

(Source RPIR; DR128)

The service had access to 24-hour mental health liaison and other specialist mental health support if staff were concerned about risks associated with a patient's mental health. Our observations of handover meetings showed that staff considered mental healthcare and referrals to the psychiatric liaison service in preparation for patients' discharge.

During the inspection we assessed how the trust provided mental healthcare in an acute medical setting. We reviewed the care records of four patients who had been admitted following an incident of self-harm. The trust had a risk assessment and management document to support staff to safely manage patients at risk of harm to self or others. In three of the four records staff had completed a risk assessment at the point of admission and had implemented a risk management plan. In one of the four records staff had not completed a risk assessment until the day after admission and in the same record staff had implemented a risk management plan which was not in line with the results of the risk assessment. The template used by staff did not allow staff to indicate whether this was a clinical judgement which meant we could not evidence whether this was a clinical judgement or staff error.

We reviewed three records of patients admitted to the trust's elderly care wards. Two of three records showed that staff had completed regular assessments of the patients' mental health using rating scales for depression or dementia. Two patients were given blue wristbands to alert staff that the patient had a cognitive impairment. The use of wristbands was not included within the patients' care plans.

There was 24-hour telephone access for patients following chemotherapy. Calls were triaged by specialist nurses and if the patient was showing signs and symptoms of neutropenic sepsis they would be admitted for urgent treatment.

Patients at risk of falls were cohorted together in one bay and staff used 'bay tagging' to ensure that a member of staff was always present in the bay to supervise patients. Staff told us one to one care was available if necessary and could be requested through the matron. Some wards had high observation beds close to nurses' station.

Daily safety huddles were held on the medical wards to update staff on patients who were most at risk.

On the day of inspection there had been a disruption in the phone lines to the wards. As part of a contingency plan all wards had been given a separate number to ring for the resuscitation team and a two-way radio if this was needed.

Nurse staffing

The service did not always have enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Despite this we found the service monitored this well and had mitigation in place to manage staffing issues. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The trust used the safer nursing care tool to calculate ward staffing levels and establishments. This tool considered the acuity and dependency of patients on the ward. A review of nurse staffing levels on wards was carried out every six months by the chief nurse. The review took account of national guidance, area specific guidance, quality and safety metrics, professional judgement, benchmarking data, patient and staff feedback/experience and other roles supporting the care in the environment.

Matrons reviewed current staffing levels on medical wards daily at safety huddles. Huddles were held at 8.30am and at regular intervals during the day. Where there were areas of concern measures to mitigate risk were agreed and additional support provided. If necessary, the decision to close beds was made, although this was rare. For example, ward 23 (respiratory ward) had closed two beds on the respiratory high dependency unit as a nurse had been moved to cover ward 1. The beds were re-opened the following morning.

There were several nurse vacancies on medical wards. Gaps in rotas were filled with bank and agency staff. Bank staff were often staff who already worked on the ward. Senior ward sisters told us they monitored the additional hours worked by ward staff as they were aware of the risk of them working too many additional hours and the adverse effect this might have on their health and well-being.

Staff were encouraged to report any concerns with staffing levels on the electronic incident reporting system. This information was included on a ward heat map which showed other quality and safety metrics.

Display boards at the entrance to the wards showed planned and actual nurse and health care assistant staffing. During the inspection we noted that planned staffing levels were met on most wards we visited. Where there was a shortfall of registered nurses we saw that staff had been deployed from other wards or there was an overallocation of health care assistants and/or nurse associates to keep staffing levels safe. The senior sister was sometimes included in the nurse staffing numbers when needed.

The wards with the highest number of vacancies were ward 23 (respiratory) and ward 6 (stroke/neurology). The nurse staffing vacancy rate for ward 23 was 18% at the time of the inspection, however, this had recently improved from 29%. Plans were in place to interview for the remaining vacant posts at the end of November. Within ward 23 there was a four bedded respiratory high dependency unit (RHDU) staffed by two registered nurses and a four bedded acute respiratory care unit (ARCU) staffed by one registered nurse and one health care assistant. The staffing levels were in line with the British Thoracic Society standards.

Ward 6 (Stroke/neurology) had a high number of nurse vacancies (see table below) and was struggling to recruit and retain staff. In addition, there were four registered nurses on long term sick and two registered nurses on maternity leave.

	Budget	Contracted	Vacancies
Registered	32.24	22.60	9.64
Unregistered	31.92	28.62	3.30
	64.16	**51.22**	**12.94**

Managers had put in place alternative methods to attract new staff including social media campaigns, regional recruitment events, offering a £2000 "golden hello" and offering joint recruitment for rotational placement with Airedale NHS trust as part of the acute provider collaboration which had been unsuccessful. This issue was on the risk register and to mitigate the risk the ward had temporarily reduced the bed base from 35 beds to 27 beds with the 8 beds re-provided on ward 26 for patients requiring rehabilitation.

Ward 6 comprised of six hyper-acute stroke (HASU) beds and 21 beds used for acute stroke, stroke rehabilitation and neurology patients. An interim nursing establishment for the ward covered the staffing for all patients including the provision of the stroke responder service as part of the HASU beds. The HASU had six beds with three registered nurses on duty at all times. There were six stroke responder nurses but three were on long term sick at the time of the inspection. Stroke responders we spoke with told us they were not always able to respond to patients with an acute stroke as they came into the emergency department because they were often needed to care for patients currently in the HASU or cover on the ward. The inability to respond to acute strokes and the reduction of beds on the stroke ward was causing delays to patients moving through the patient pathway. Service managers had submitted a paper to the senior leadership team with recommendations to establish a separate stroke responder service covering the 24-hour period, 7 days per week. This had been accepted, however, it was recognised that a phased approach would be needed to enable recruitment to backfill for the ward.

Nurses handed over their patients to new staff coming onto shift twice a day. We saw that handover sheets were updated, comprehensive and included do not attempt resuscitation (DNACPR) status. We observed a consultant handing over to the senior sister on ward 1 following a ward round. Each patient was discussed in detail with a plan of care to be discharged or moved to another ward for further tests.

The service had a number of nurse associates working on the wards and were supporting further health care assistants on the programme.

Trust level

The table below shows a summary of the nursing staffing metrics in medicine at trust level compared to the trust's targets, where applicable:

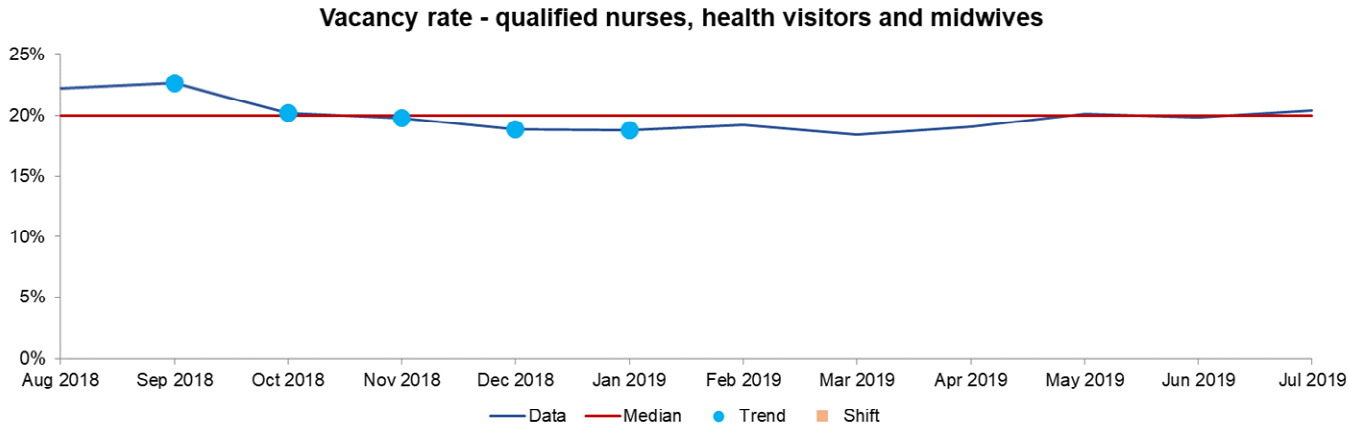
	Medicine annual staffing metrics						
	August 2018 to July 2019						
Staff group	**Annual average establishment**	**Annual vacancy rate**	**Annual turnover rate**	**Annual sickness rate**	**Annual bank hours (% of available hours)**	**Annual agency hours (% of available hours)**	**Annual unfilled hours (% of available hours)**
Target		0.0%	0.0%	4.5%			
All staff	1,610	17.6%	8.4%	4.9%			

Qualified nurses	468.1	19.9%	10.3%	4.6%	63,099 (9%)	63,982 (9%)	33,974 (5%)

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing bank agency tabs)

Nurse staffing rates within medicine were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover, sickness or bank use.

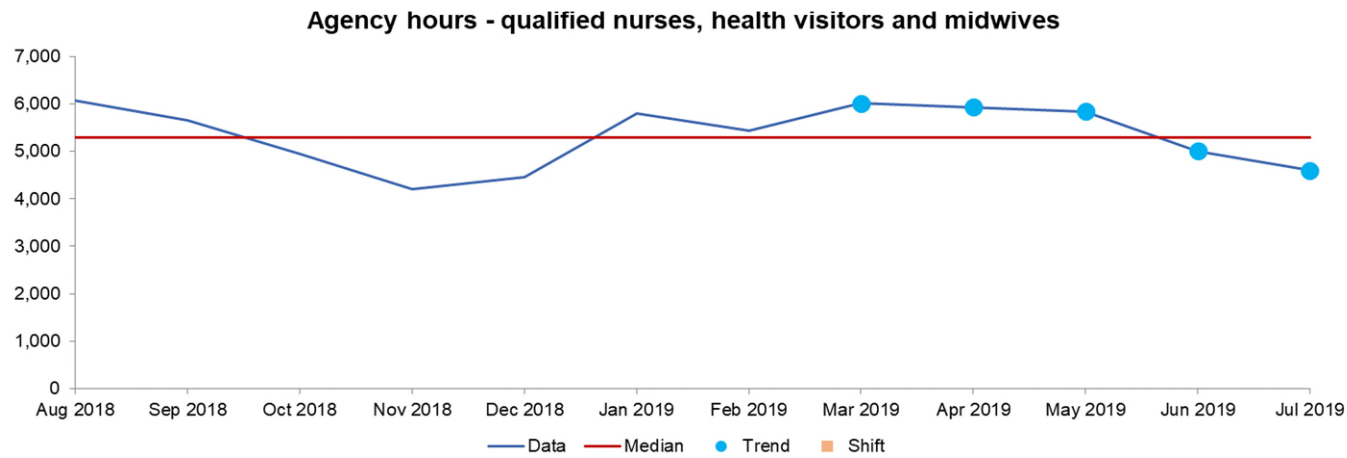
Vacancy rates



Monthly vacancy rates over the last 12 months for qualified nurses, health visitors and midwives shows a downward trend from September 2018 to January 2019. This could be an early indicator of improvement.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Agency staff usage



Monthly agency hours over the last 12 months for qualified nurses, health visitors and midwives show a downward trend from March 2019 to July 2019.

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

Bradford Royal Infirmary

The table below shows a summary of the nursing staffing metrics in medicine at Bradford Royal Infirmary compared to the trust's targets, where applicable:

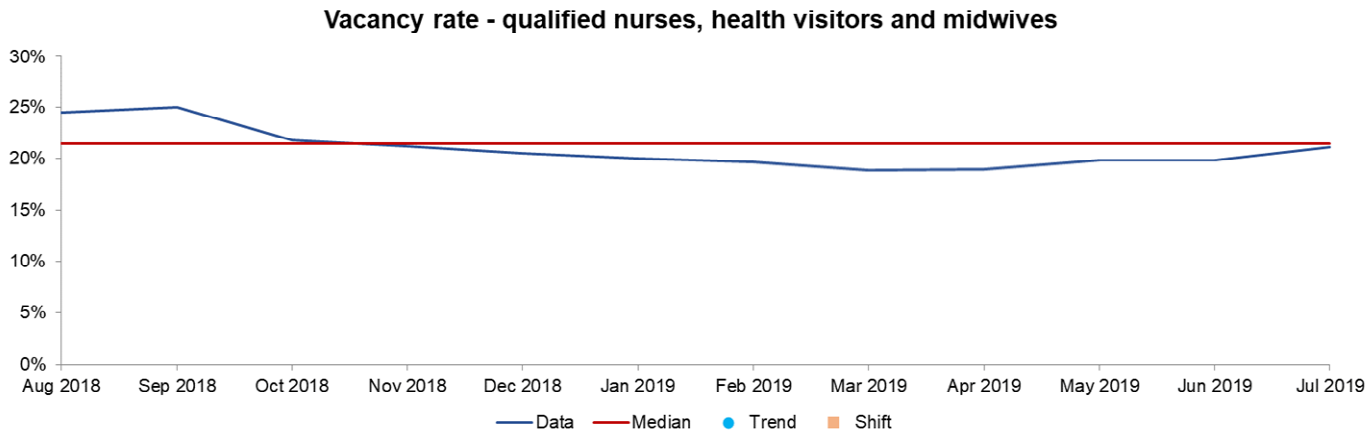
	Medicine annual staffing metrics						
	August 2018 to July 2019						
Staff group	**Annual average establishment**	**Annual vacancy rate**	**Annual turnover rate**	**Annual sickness rate**	**Annual bank hours (% of available hours)**	**Annual agency hours (% of available hours)**	**Annual unfilled hours (% of available hours)**
Target		0.0%	0.0%	4.5%			
All staff	1,503.1	16.9%	7.8%	4.5%			
Qualified nurses	420.5	20.9%	9.7%	4.2%	N/A*	N/A*	N/A*

NOTE*: The trust was unable to specify their bank and agency usage at site level.

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing Bank Agency tabs)

Nurse staffing rates within medicine at Bradford Royal Infirmary were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for sickness, turnover, bank use or agency use.

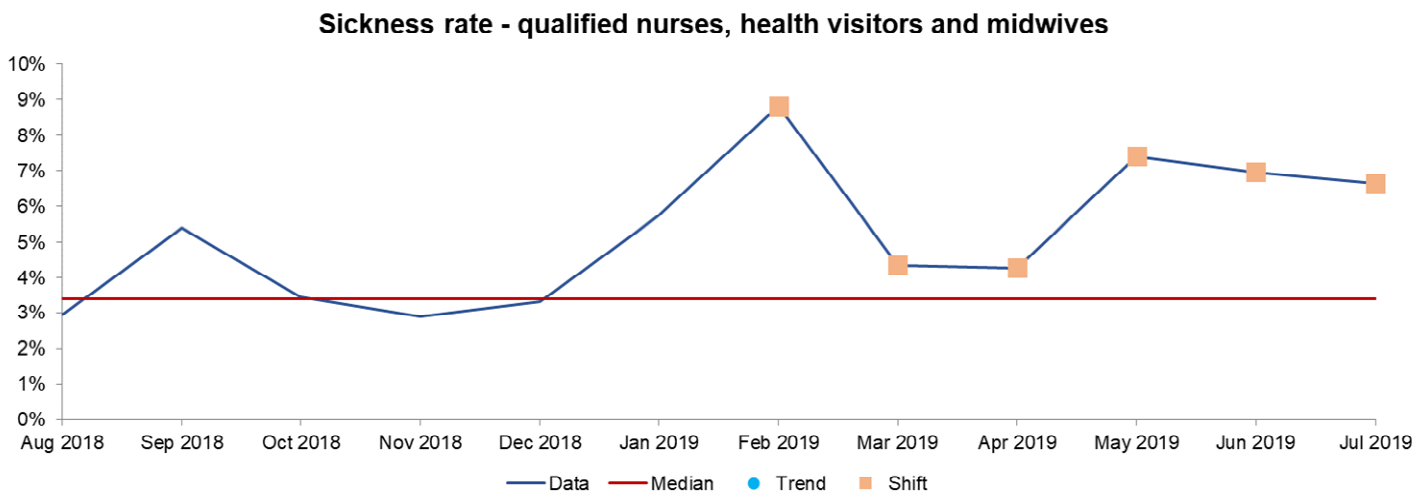
Vacancy rates



Monthly vacancy rates over the last 12 months for qualified nurses, health visitors and midwives are not stable and may be subject to ongoing change.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Sickness rates



Monthly sickness rates over the last 12 months for qualified nurses, health visitors and midwives shows a shift from February 2019 to July 2019. This could be an indicator of change.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Medical staffing

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

There was seven-day consultant cover on the acute medical units. During the week a consultant was present from 8am to 9pm then on call overnight from home. At the weekend there were two consultants on the morning ward round 8am until 2pm, with the first on call consultant returning in the early evening to do a second ward round but otherwise on call from home.

Medical staffing at nights (and weekends) for the medical care service was one specialist registrar (SpR), three core trainee doctors (CT1 or CT2) based on the acute medical units and one core trainee doctor and one junior doctor (FY1/FY2) to cover the medical wards. There was a consultant available on call from home.

Consultants in the stroke service worked closely with their colleagues in Airedale NHS trust and shared the acute stroke on call rota. There were two specialist stroke consultants at Bradford Royal Infirmary and the stroke service was in the process of recruiting two additional consultants, one for Bradford and one for Airedale. Patients were reviewed by a consultant seven days a week in hyperacute stroke unit.

The service had eight cardiology consultants who were available to review all patients on the cardiology ward and the coronary care unit seven days a week.

There were 12 (nine wte) consultants in elderly care. There was an on-call consultant rota for weekends who would be on site between 8am and 4pm to see all new patients and any other patients who required a medical review. After this time, they were on call from home.

There were five respiratory consultants. All patients in respiratory high dependency unit (RHDU) and acute respiratory care unit (ARCU) received a daily consultant review of their plan of care, with a minimum standard of senior review within 18 hours of admission, seven days per week. The weekend cover was delivered by a combination of acute physicians and respiratory consultants until 2pm with overnight responsibility defaulting to the first on call for general medicine who was covering

the acute medical units over the weekend. The respiratory service was planning to develop an out of hours respiratory rota however this was not yet in place.

Physician associates were on placement in the acute medical units.

Junior doctors told us they were well supported by consultants and had time for learning.

Trust level

The table below shows a summary of the medical staffing metrics in medicine at trust level compared to the trust's targets, where applicable:

	Medicine annual staffing metrics August 2018 to July 2019						
Staff group	**Annual average establishment**	**Annual vacancy rate**	**Annual turnover rate**	**Annual sickness rate**	**Annual bank hours (% of available hours)**	**Annual locum hours (% of available hours)**	**Annual unfilled hours (% of available hours)**
Target		0.0%	0.0%	4.5%			
All staff	1,610.1	17.6%	8.4%	4.9%			
Medical staff	356.2	3.2%	10.3%	1.3%	11,540 (4%)	9,410 (3%)	10,320 (4%)

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)

Medical staffing rates within medicine were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy, sickness, turnover, bank or agency use.

Bradford Royal Infirmary

The table below shows a summary of the medical staffing metrics in medicine at Bradford Royal Infirmary compared to the trust's targets, where applicable:

	Medicine annual staffing metrics August 2018 to July 2019						
Staff group	**Annual average establishment**	**Annual vacancy rate**	**Annual turnover rate**	**Annual sickness rate**	**Annual bank hours (% of available hours)**	**Annual locum hours (% of available hours)**	**Annual unfilled hours (% of available hours)**
Target		0.0%	0.0%	4.5%			
All staff	1,503.1	16.9%	7.8%	4.5%			
Medical staff	355.8	3.2%	9.4%	1.1%	N/A*	N/A*	N/A*

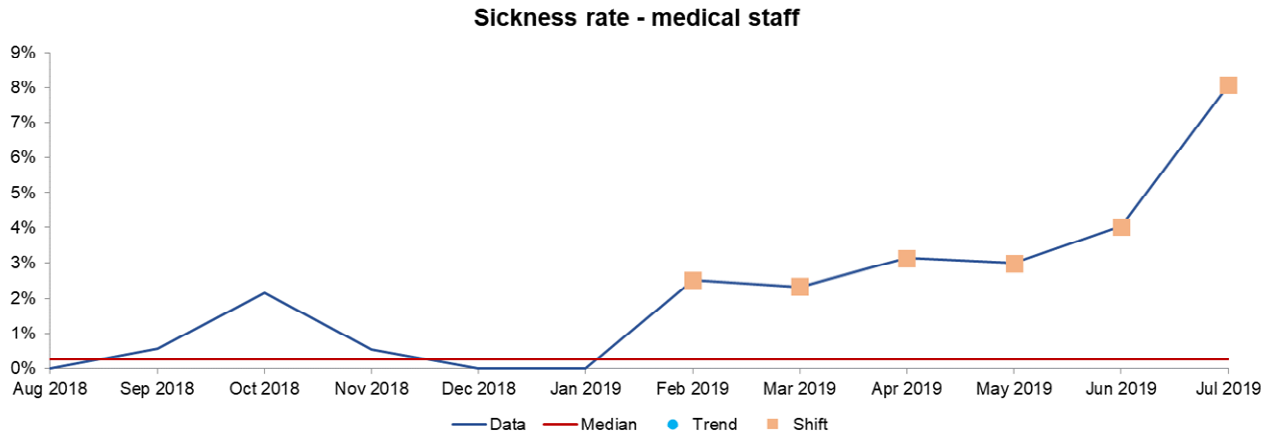
NOTE*: The trust was unable to specify their bank and agency usage at site level for Bradford Royal Infirmary.

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)

Medical staffing rates within medicine at Bradford Royal Infirmary were analysed for the past 12

months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy, sickness, turnover, bank use or agency use.

Sickness rates



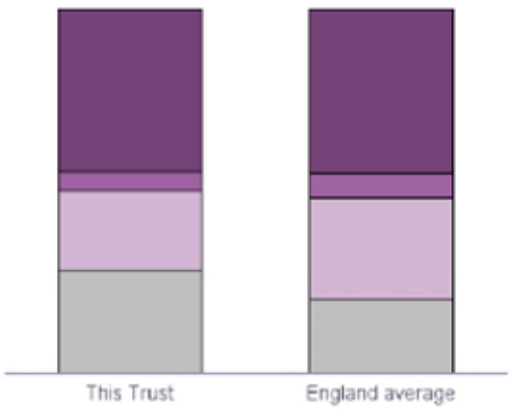
Monthly sickness rates over the last 12 months for medical staff shows a shift from February 2019 to July 2019. This could be an indicator of change.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Staffing skill mix

In May 2019, the proportion of consultant staff reported to be working at the trust was about the same as the England average and the proportion of junior (foundation year 1-2) staff was higher than the England average.

Staffing skill mix for the 176 whole time equivalent staff working in medicine at Bradford Teaching Hospitals NHS Foundation Trust



	This Trust	England average
Consultant	45%	45%
Middle career^	5%	7%
Registrar group~	22%	28%
Junior*	28%	20%

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital - Workforce Statistics - Medical)

Records

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

Records of patients' care and treatment were all kept on an electronic patient record system. Patients medication charts were also kept on the electronic system. The system had been in use since September 2017, so staff were familiar with and engaged well with it. The only records which were paper based were the moving and handling assessment and plan which were kept at the patient's bedside.

We reviewed 12 records at this hospital and found that the standard of record keeping was good. The initial nursing assessment, risk assessments, pain charts, intentional rounding charts were all completed well. Nursing staff also recorded patient observations on the electronic system.

Medical notes were comprehensive, and all patients had a documented history and plan of care. There was clear evidence of medical review within 14 hours of admission, ongoing medical reviews and multidisciplinary involvement where needed. We also reviewed two do not resuscitate orders and found them to be correctly and thoroughly completed.

Using the EPR meant that when patients transferred to a new team, there were no delays in staff accessing their records.

Staff had to log onto the system individually which ensured the records were secure. We did not observe any breaches in security during the inspection.

Data provided by the trust, showed that 78.1% of medical staff and 81.9%% of nursing staff had completed information governance training, the trust target was 95%.

Medicines

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

The service followed best practice when prescribing, giving, recording and storing medicines. Medicines, including controlled drugs and intravenous fluids, were stored securely and access was restricted to authorised staff.

Oxygen prescribing had improved. We checked the medication charts of eight patients on oxygen and found they were correctly prescribed and managed. All oxygen cylinders we checked were stored securely and within their expiry date.

We saw evidence on all wards we visited that nurses checked controlled drugs (CDs) in line with policy. There were separate CD registers for patients own medicines, registers were completed correctly. The CDs we checked were all within their expiry date with the exception of ward 6 (stroke and neurology) where we found five controlled drugs with expiry dates ranging from May 2019 to October 2019. The nurse in charge was aware of this and had requested the pharmacy team to collect and destroy them. Staff told us a full-time pharmacy technician was starting work on the ward the week following our inspection. All other stock medicines we checked were within their expiry date.

Wards 29 and 31 had a tracking system in place for staff to gain access to CDs. Staff were able to access the CD storage cabinet using a swipe card with two staff present.

An audit of controlled drugs on all medical wards was carried out by the service in September 2019. The audit showed some areas of good compliance and some areas which required improvement. Recommendations were made for all areas which performance had slipped or improvement was

needed. Safe and secure storage of medicines was also monitored through the trust's ward accreditation scheme.

Drugs for emergency use were kept in a crash box on the resuscitation trolley. The expiry date was clearly marked on the outside of the box, so staff knew when they would need to be replaced. All we observed were within their expiry date.

Fridges used to store medicine were checked daily and there were clear instructions for staff on what to do if the fridge was out of the correct temperature range.

The nurse in charge of each ward completed a daily checklist to ensure that the required checks of hypo boxes, emergency oxygen and controlled drugs were carried out. The checks also included whether the fridge checks had been completed and required action taken and that medication trollies and cupboards were locked. We saw the daily checklists were completed on the wards we visited.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. We saw medicine alerts and drugs safety updates were circulated and discussed at governance meetings.

Staff reported good support from pharmacy with wards receiving visits from pharmacy technicians from Monday to Friday. Staff told us that pharmacy technicians working at band five, could organise patient's medication to take home (TTO). There was limited pharmacy cover at weekends, pharmacy services were available from 9am to 12pm on Saturdays and Sundays. Staff said this sometimes caused delays in discharging patients over the weekend period.

The trust had introduced the role of ward pharmacy assistant who ensured that ward medicine cupboards were properly stocked and secured, medicine returns were processed in a timely manner and dispensed medicines to take home and hand delivering them back to the wards once checked.

Incidents

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

Staff raised concerns and reported incidents and near misses in line with trust/provider policy. Staff we spoke with knew how to report incidents on the electronic system and said they were encouraged to do so. Staff could describe to us what would they would report as an incident.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff told us they received feedback from incidents and could give examples of learning from incidents shared at daily safety huddles. Staff told us they received a number of bulletins which contained information about learning from incidents such as the 'learning matters' bulletin.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong.

Managers investigated incidents thoroughly. We reviewed a route cause analysis investigation report for a serious incident and found that the incident was investigated thoroughly and fairly. Clear recommendations and an action were included to reduce the risk of the incident reoccurring. The patient and their family were involved in the investigation and duty of candour was applied. Support was offered to staff involved in the serious incident.

Mortality reviews and lessons learnt were shared with staff through speciality meetings. The approach to these meetings and their minutes varied across specialities. Most specialities ran a schedule of mortality and morbidity meetings, but some took the form a case by case review of completed mortality reviews either using the completed review or in presentation form. Some specialities discussed cases and share learning as part of their speciality quality and safety meetings. Most junior doctors we spoke with said they were encouraged to attend the meetings were morbidity and mortality were discussed.

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From August 2018 to July 2019, the trust did not report any never events for medicine.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

Trust level

In accordance with the Serious Incident Framework 2015, the trust reported 13 serious incidents (SIs) in medicine which met the reporting criteria set by NHS England from August 2018 to July 2019. A breakdown of the incident types reported is in the table below:

Incident type	Number of incidents	Percentage of total
Pressure ulcer meeting SI criteria	6	46.1%
Treatment delay meeting SI criteria	2	15.4%
Slips/trips/falls meeting SI criteria	1	7.7%
Diagnostic incident including delay meeting SI criteria (including failure to act on test results)	1	7.7%
Medication incident meeting SI criteria	1	7.7%
Sub-optimal care of the deteriorating patient meeting SI criteria	1	7.7%
Ongoing slips/trips/falls meeting SI criteria	1	7.7%
Total	**13**	**100.0%**

(Source: Strategic Executive Information System (STEIS))

Safety thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

The safety thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

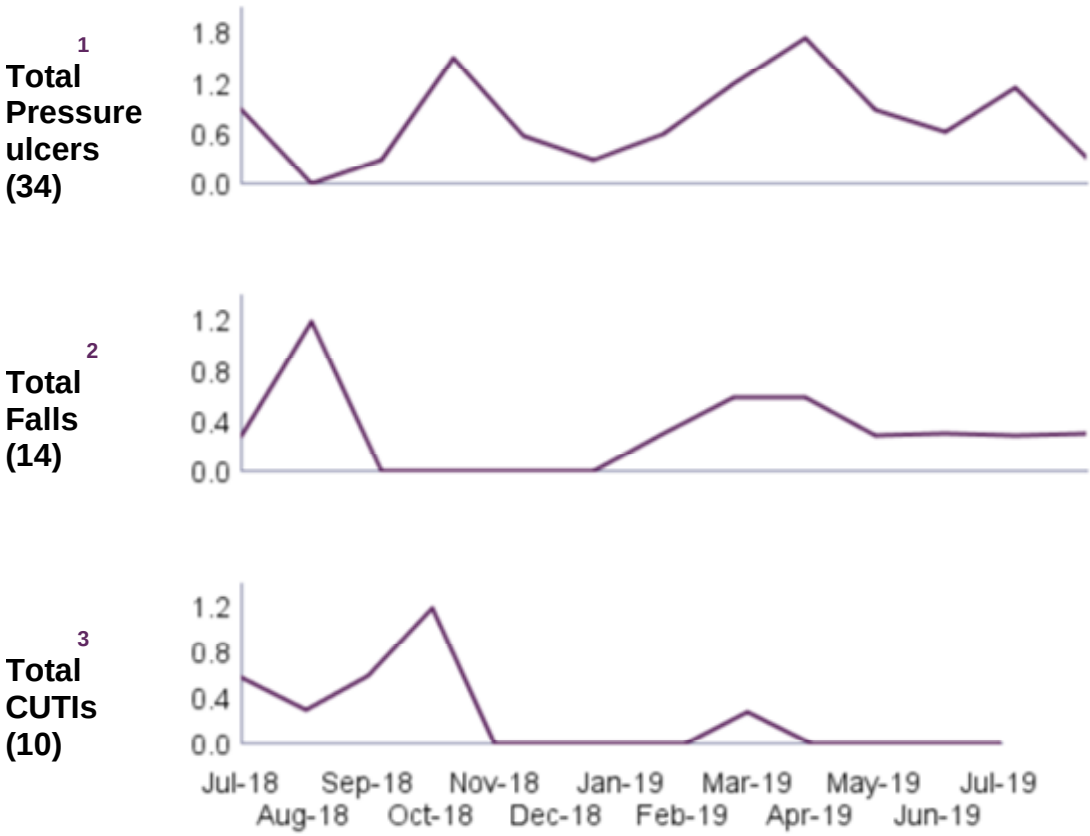
Data collection takes place one day each month. A suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the patient safety thermometer showed that the trust reported 34 new pressure ulcers, 14 falls with harm and 10 new urinary tract infections in patients with a catheter from July 2018 to July

2019 for medical services.

Safety thermometer data was displayed on wards for staff and patients to see. For example, ward 3 had achieved 100% harm free care in November 2019.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter acquired urinary tract infections at Bradford Teaching Hospitals NHS Foundation Trust



1 Pressure ulcers levels 2, 3 and 4
2 Falls with harm levels 3 to 6
3 Catheter acquired urinary tract infection level 3 only

(Source: NHS Digital - Safety Thermometer)

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff had access to policies and procedures and other evidence-based guidance via the trust intranet. Clinical policies had been developed based on national guidance such as the National Institute for Health and Care Excellence (NICE). At the previous inspection we found that several policies and guidance had gone past their review date. At this inspection we checked six clinical guidelines and polices, for example, guidelines on asthma and atrial fibrillation, and found they were all within their review date.

The service had a system to ensure that all newly published clinical guidance was reviewed and considered. All new guidance was discussed at a monthly meeting and if considered applicable it was forwarded to the relevant clinical lead and governance and quality officer. The clinical leads were asked to consider any variance between current practice and what was recommended in the guidance, and what measures needed to be taken in order to implement the guideline in full. Where the service was not able to fully comply with the implementation of NICE guidance, an assessment of risk was undertaken, and mitigation was put in place to reduce the risk.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Signage was in place to make it clear which patients had modified diets or were nil by mouth.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Red trays and jugs were in use for patients identified as at risk and those needing assistance at mealtimes.

Specialist support from staff such as dieticians and speech and language therapists were available for patients who needed it. There was a dedicated dietician for ward 6 (stroke and neurology).

There was an ongoing hydration awareness program with monitoring and assessment tools in place and hydration stations placed in wards.

We saw that staff fully and accurately completed patients' fluid and nutrition charts where needed.

Wards had protected mealtimes to enable staff to serve food and give assistance and support to patients.

There were dining tables and chairs in the bays on ward 29 and 31 (elderly care). Staff encouraged patients to eat their meals at the table with other patients to create more sociable meal times.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice.

Patients told us their pain was well managed and they received pain relief soon after requesting it.

Staff prescribed, administered and recorded pain relief accurately.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements. Performance in national audits did not always demonstrate good outcomes for patients. The service had not been accredited under the Joint Advisory Group on Endoscopy.

The service participated in relevant national clinical audits. Outcomes for patients were variable and did not always meet national standards.

The endoscopy unit had failed to achieve the Joint Advisory Group on Endoscopy (JAG) accreditation in March 2018. Staff explained this was due to concerns with patient flow and staff competencies. In addition, the unit had not been able to provide accurate waiting times at the time of the JAG inspection due to the migration of approximately 5,000 patient records onto a new electronic records system in 2017. The service had appointed a new manager to implement an action plan to regain JAG accreditation. Staff told us that JAG would be carrying out a reinspection in early 2020 and the unit was online to achieve this.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. The service participated in local audit to ensure that staff and services were working effectively. Local audits included infection control, medicine management and NEWS2.

The trust operated a ward accreditation scheme. Wards were inspected by colleagues from other wards rated against several areas including nutrition and hydration, infection control, safeguarding, pressure ulcers, falls and medicines management. Depending on their results they were given a red, amber or green rating with an action plan for any areas which required improvement. Wards rated as green were re-inspected in one year, those rated amber in six months and those rated red in two months to ensure that the action plans had been completed. Ward displayed their ward accreditation ratings and staff were proud of their achievement if they were rated green. If a ward gained a green rating three times a row they were classed as an ‘exemplar ward’ and in recognition for this the ward senior sister was given a ward matron uniform and badge. The most recent results showed that all medical wards had received a green rating apart from three which were rated amber. Ward 22 had achieved exemplar ward status. We saw that appropriate action plans were completed for the three medical wards which were rated amber.

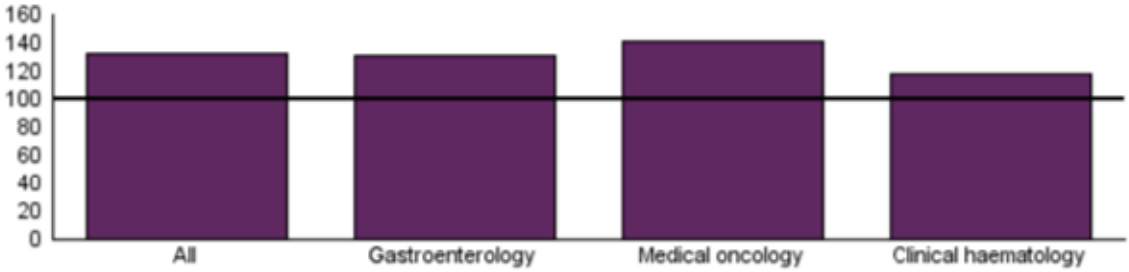
Relative risk of readmission

Trust level

From February 2018 to January 2019, patients at the trust had a higher than expected risk of readmission for elective admissions and a higher than expected risk of readmission for non-elective admissions when compared to the England average.

Elective Admissions – Trust level

- Patients in gastroenterology, medical oncology and clinical haematology had a higher than expected risk of readmission for elective admissions

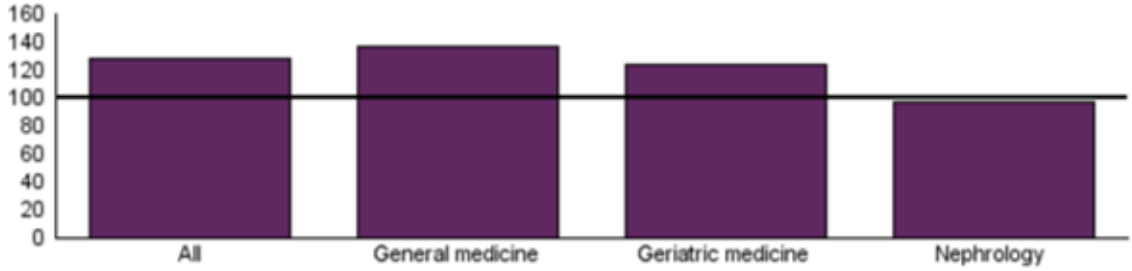


Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 represents the opposite. Top

three specialties for specific trust based on count of activity.

Non-Elective Admissions – Trust level

- Patients in general medicine and geriatric medicine had a higher than expected risk of readmission for non-elective admissions
- Patients in nephrology had a similar to expected risk of readmission for non-elective admissions



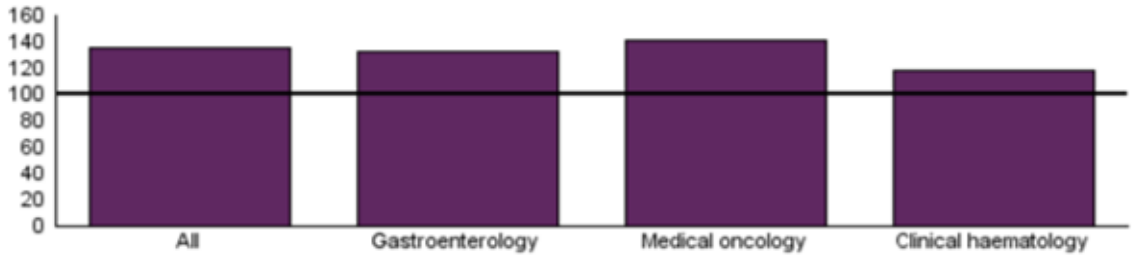
Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 represents the opposite. Top three specialties for specific trust based on count of activity.

Bradford Royal Infirmary

From February 2018 to January 2019, patients at Bradford Royal Infirmary had a higher than expected risk of readmission for elective admissions and a higher than expected risk of readmission for non-elective admissions when compared to the England average.

Elective Admissions - *Bradford Royal Infirmary*

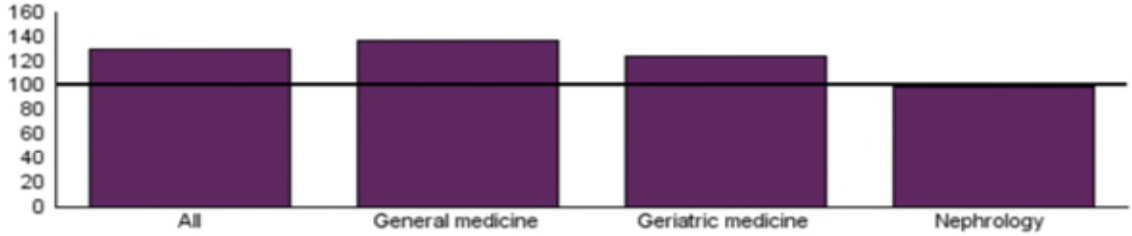
- Patients in gastroenterology, medical oncology and clinical haematology had a higher than expected risk of readmission for elective admissions



Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 represents the opposite. Top three specialties for specific site based on count of activity.

Non-Elective Admissions - *Bradford Royal Infirmary*

- Patients in general medicine and geriatric medicine had a higher than expected risk of readmission for non-elective admissions
- Patients in nephrology had a lower than expected risk of readmission for non-elective admissions



Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive

finding, as this means there were fewer observed readmissions than expected. A value above 100 represents the opposite. Top three specialties for specific site based on count of activity.

(Source: Hospital Episode Statistics - HES - Readmissions (February 2018 to January 2019))

The data below shows an improvement the Sentinel Stroke National Audit Programme (SSNAP) rating since our last inspection. However, at the time of the inspection stroke nurse responders were covering for vacancies and sickness on the stroke ward and were not able to leave the ward to respond to a patient arriving at the hospital with an acute stroke. This led to negative patient outcomes in thrombolysis and contributed to a downgraded rating from B to C in the April to June 2019 audit data. The service was working to an ongoing action plan which included plans to implement a stand-alone stroke responder service.

Sentinel Stroke National Audit Programme (SSNAP)

Bradford Royal Infirmary takes part in the quarterly Sentinel Stroke National Audit programme. On a scale of A-E, where A is best, the trust achieved grade B in latest audit, January to March 2019.

Bradford Royal Infirmary

Overall Scores	Apr 18 - Jun 18	Jul 18 - Sep 18	Oct 18 - Dec 18	Jan 19 - Mar 19
SSNAP level	C↑↑	B↑	B	B
Case ascertainment band	A	A	A	A
Audit compliance band	A	A	A	A
Combined total key indicator level	C↑↑	B↑	B	B

Best A B C D E Worst N/A No assessment

- Domain 2: Stroke unit has seen a decline in team centred performance in the latest audit (level D) compared to the previous audit (level C) (this applies to team and patient).
- Domain 3: Thrombolysis has seen a decline in patient and team centred performance in the latest audit (level D) compared to the previous audit (level C).
- Domain 7: Speech and language therapy has seen a decline in patient centred performance in the latest audit (level D) compared to the previous audit (level C).
- Domain 8: Multi-disciplinary team working has seen a decline in patient and team centred performance in the latest audit (level C) compared to the previous audit (level B).
- Domain 10: Discharge processes has seen an improvement in patient centred performance in the latest audit (level A) compared to the previous audit (level B).
- All other metrics have shown no change in performance in the last two periods.

Patient centred performance	Apr 18 - Jun 18	Jul 18 - Sep 18	Oct 18 - Dec 18	Jan 19 - Mar 19
Domain 1: Scanning	C↑	C	C	C
Domain 2: Stroke unit	E	E↓	C↑↑	D↓
Domain 3: Thrombolysis	E	E	C↑↑	D↓
Domain 4: Specialist assessments	B↑↑	B	B	B
Domain 5: Occupational therapy	A↑↑↑↑	A	A	A
Domain 6: Physiotherapy	B↑↑↑	A↑	A	A
Domain 7: Speech and language therapy	D↑	C↑	C	D↓
Domain 8: Multi-disciplinary team working	B↑↑	B	B	C↓

Domain 9: Standards by discharge	B↑	A↑	A	A
Domain 10: Discharge processes	B	B	B	A↑
Patient-centred total key indicator level	C↑↑	B↑	B	B

Best A B C D E Worst N/A No assessment

- Note that for patient centred performance, the latest period has higher scores in five domains compared to the first period; only one domain has got worse. There are four domains with A compared to one in the first period.

Team centred performance	Apr 18 - Jun 18	Jul 18 - Sep 18	Oct 18 - Dec 18	Jan 19 - Mar 19
Domain 1: Scanning	C↑	C	C	C
Domain 2: Stroke unit	D↑	E↓	C↑↑	D↓
Domain 3: Thrombolysis	E	E	C↑↑	D↓
Domain 4: Specialist assessments	B↑↑	B	B	B
Domain 5: Occupational therapy	A↑↑↑↑	A	A	A
Domain 6: Physiotherapy	A↑↑↑	A	A	A
Domain 7: Speech and language therapy	C↑↑	C	C	C
Domain 8: Multi-disciplinary team working	B↑	B	B	C↓
Domain 9: Standards by discharge	B↑	A↑	A	A
Domain 10: Discharge processes	A↑	A	A	A
Team-centred total key indicator level	B↑↑	B	B	B

Best A B C D E Worst N/A No assessment

(Source: Royal College of Physicians London, SSNAP audit)

National Diabetes Inpatient Audit

The trust participated in the National Diabetes Inpatient Audit.
Results from the audit completed in May 2019 found no key successes were identified. Concerns included a gap in compliance with recommendations of a seven day service from inpatient specialist nurses and access to a specialist dietician. The trust did not use any web ketone monitors that were linked to the internet. Actions had been put in place, the trust was compliant with 80% of recommendations and partially compliant with a further 10%.

Work was ongoing to discuss specialist dietician for inpatient services and scoping to increase staffing to look at covering seven day service. Remote ketone monitoring was being investigated by the point of care testing team.
(Source -PIR- P35)

Lung Cancer Audit

The table below summarises Bradford Teaching Hospitals NHS Foundation Trust's performance in the 2018 National Lung Cancer Audit.

Metrics *(Audit measures)*	**Trust performance**	**Comparison to other Trusts**	**Met national**

	(2016 performance)		**standard?**
Crude proportion of patients seen by a cancer nurse specialist *(Access to a cancer nurse specialist is associated with increased receipt of anticancer treatment)*	86.5% (32%)	Does not meet the audit aspirational standard	Did not meet
Case-mix adjusted one-year survival rate *(Adjusted scores take into account the differences in the case-mix of patients treated)*	32.8% (37%)	Within expected range	No current standard
Case-mix adjusted percentage of patients with Non Small Cell Lung Cancer (NSCLC) receiving surgery *(Surgery remains the preferred treatment for early-stage lung cancer; adjusted scores take into account the differences in the case-mix of patients seen*)	15.2% (18%)	Within expected range	Did not meet
Case-mix adjusted percentage of fit patients with advanced NSCLC receiving systemic anti-cancer treatment *(For fitter patients with incurable NSCLC anti-cancer treatment is known to extend life expectancy and improve quality of life; adjusted scores take into account the differences in the case-mix of patients seen*)	77.1% (68%)	Within expected range	Met
Case-mix adjusted percentage of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy *(SCLC tumours are sensitive to chemotherapy which can improve survival and quality of life; adjusted scores take into account the differences in the case-mix of patients seen)*	66.6% (74%)	Within expected range	Did not meet

(Source: National Lung Cancer Audit 2018)

Trust performance in the lung cancer audit for 2018 did not meet the national standard (90%) in three out of the five audit metrics but were within the expected range compared to other trusts. Compared to the 2016 audit results performance had decreased in four out of the five metrics. A local action plan was in place to improve audit results.

Following our inspection, we checked audit data from the lung cancer audit carried out in May 2019. We saw that the proportion of patients seen by a cancer nurse specialist (86.5%) was better than the national average of 72.1% and the regional average of 83.4%.
(Source Universal PIR -P35)

National Audit of Inpatient Falls

Bradford Royal Infirmary

The table below summarises Bradford Royal Infirmary's performance in the 2017 National Audit of Inpatient Falls. The audit reports on the extent to which key indicators were met and grades performance as red (less than 50% of patients received the assessment/intervention), amber (between 50% and 79% of patients received the assessment/intervention) and green (more than 80% of patients received the assessment/intervention.

Metrics ***(Audit measures)***	**Hospital performance**	**Audit's Rating**	**Met national aspirational standard?**
Does the trust have a multidisciplinary working group for falls prevention where data on falls are discussed at most or all the meetings?	Yes	N/A	Met
Crude proportion of patients who had a vision assessment (if applicable) *(Having a vision assessment is indicative of good practice in falls prevention)*	6.7%	Red	Did not meet
Crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) *(Having a lying and standing blood pressure assessment is indicative of good practice in falls prevention*)	11.1%	Red	Did not meet
Crude proportion of patients assessed for the presence or absence of delirium (if applicable) *(Having an assessment for delirium is indicative of good practice in falls prevention)*	59.4%	Amber	Did not meet
Crude proportion of patients with a call bell in reach (if applicable) (*Having a call bell in reach is an important environmental factor that may impact on the risk of falls*)	64.0%	Amber	Did not meet

(Source: National Audit of Inpatient Falls 2017)

The results for the National Audit of Inpatient Falls (2017) showed that only one audit metric was met and of the remaining four, two were rated as red and two as amber. We saw that there was a local action plan in place to improve audit performance and this had been superseded by the introduction of the Falls CQUIN from April 2019. The trust falls steering group was engaged with this CQUIN.

Chronic Obstructive Pulmonary Disease Audit

Bradford Royal Infirmary

The table below summarises Bradford Royal Infirmary's performance in the 2018/19 Chronic Obstructive Pulmonary Disease Audit.

Metrics ***(Audit measures)***	**Hospital performance**	**Audit's Rating**	**Met national standard?**
Percentage of patients seen by a member of the respiratory team within 24hrs of admission? *(Specialist input improves processes*	16.9%	Worse than the national aggregate	Did not meet

and outcomes for COPD patients)			
Percentage of patients receiving oxygen in which this was prescribed to a stipulated target oxygen saturation (SpO2) range (of 88-92% or 94-98%) *(Inappropriate administration of oxygen is associated with an increased risk of respiratory acidosis, the requirement for assisted ventilation, and death)*	98.9%	Worse than the national aggregate	Did not meet
Percentage of patients receiving non-invasive ventilation (NIV) within the first 24 hours of arrival who do so within 3 hours of arrival *(NIV is an evidence-based intervention that halves the mortality if applied early in the admission*)	Not available	Not available	Not available
Percentage of documented current smokers prescribed smoking-cessation pharmacotherapy *(Smoking cessation is one of the few interventions that can alter the trajectory of COPD)*	20.6%	Worse than the national aggregate	Did not meet
Percentage of patients for whom a British Thoracic Society, or equivalent, discharge bundle was completed for the admission (*Completion of a discharge bundle improves readmission rates and integration of care*)	14.3%	Worse than the national aggregate	Did not meet
Percentage of patients with spirometry confirming FEV1/FVC ratio <0.7 recorded in case file (*A diagnosis of COPD cannot be made without confirmatory spirometry and the whole pathway is in doubt*)	5.7%	Worse than the national aggregate	Did not meet

(Source: Chronic Obstructive Pulmonary Disease Audit 2018/19)

The results of the 2018/19 Chronic Obstructive Pulmonary Disease showed that five out of the six audit metrics were worse than the national aggregate and did not meet the national standard. One audit metric was not available. We saw that there was a local action plan in place to improve audit performance.

After our inspection we reviewed updated data. It showed;

- Review by a member of the respiratory team (and review within 24 hours) was lower (worse) than nationally (BTHFT 46.8% against national 84.7%).
- The average time from admission to respiratory review was higher (worse) than national average.
- Oxygen prescribed was lower (worse) than the national average (BTHFT 36.5% against national 72.0%).

- Acute treatment with NIV received within 2 hours of arrival is lower (worse) than national (BTHFT 6.5% against national 21%).
- Spirometry result available in 4.4% cases, worse than nationally (40.5%)
- Smoking status recorded was lower (worse) than nationally (BTHFT 84.3% against national 94.0%)
- Smoking cessation pharmacotherapy offered during admission was lower than nationally (BTHFT 38.6% against national 67.1%).
- British Thoracic Society Bundle (or equivalent) completed was lower (worse) than nationally (BTHFT 9.2% against national 70.3%).
- Follow-up arrangements made was lower (worse) than nationally (BTHFT 36.9% against national 83.7%).

(Source PIR- tab-P35)

National Audit of Dementia

Bradford Royal Infirmary

The table below summarises Bradford Royal Infirmary's performance in the 2017 National Audit of Dementia.

Metrics *(Audit measures)*	**Hospital performance**	**Audit's Rating**	**Met national standard?**
Percentage of carers rating overall care received by the person cared for in hospital as Excellent or Very Good *(A key aim of the audit was to collect feedback from carers to ask them to rate the care that was received by the person they care for while in hospital)*	72.4%	Similar	No current standard
Percentage of staff responding "always" or "most of the time" to the question "Is your ward/ service able to respond to the needs of people with dementia as they arise?" *(This measure could reflect on staff perception of adequate staffing and/or training available to meet the needs of people with dementia in hospital)*	89.8%	Better	No current standard
Mental state assessment carried out upon or during admission for recent changes or fluctuation in behaviour that may indicate the presence of delirium *(Delirium is five times more likely to affect people with dementia, who should have an initial assessment for any possible signs, followed by a full clinical assessment if necessary*)	51.0%	Similar	No current standard
Multi-disciplinary team involvement in discussion of discharge	78.9%	Similar	No current standard

(Timely coordination and adequate discharge planning is essential to limit potential delays in dementia patients returning to their place of residence and avoid prolonged admission)			

(Source: National Audit of Dementia 2017)

After our inspection we reviewed updated data. We saw;

- 100% of patients had a personal information document (better than the national average 59%).
- 100% of patients living with dementia had a nutritional assessment completed.

The trust told us the data submitted to the audit had been checked and data quality concerns have been identified, as the data presented in the report was felt not to reflect clinical practice.
The trust's dementia lead planned to re-audit a number of standards where data quality was to be not robust, to clarify current compliance.

There had been an audit of delirium in 2018; results showed;

- Nursing plan for delirium / pathway for delirium in the notes was higher (better) than national average (BTHFT 36.4% against National average 19.5%).
- Patient assessed for constipation as a possible cause of delirium at or within 24 hours of admission was higher (better) than national average (BTHFT 45.5% against National average 41.2%).
- Patient assessed for pain as a possible cause of delirium, at or within 24 hours of admission was 100% against National average of 52.7%.
- Standardised cognitive test was repeated before the patient was discharged from hospital (BTHFT 20% against National average 11.9%).

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Newly qualified registered nurses had a preceptorship package in place and were supernumerary for a period of two to three weeks. They were given an acorn badge to identify that they were newly qualified. The ward manager on the acute medical unit had developed a checklist for newly qualified staff to assist them with their learning and development.

Wards used regular bank and agency nursing staff to fill gaps in staffing. All staff received an induction and were trained in the use of the electronic record system. Bank staff we spoke with told us they received a good induction and ongoing support.

Patients in the acute phase of respiratory failure requiring non-invasive ventilation (NIV) received care on the respiratory high dependency unit (RHDU) located on ward 23 or on the intensive care unit. All nursing staff working on the RHDU had completed competencies in NIV; this included any agency or bank staff who worked on the unit. Training was planned for all newly qualified nurses on the ward.

Medical wards supported student nurses on placement. Students we spoke with on ward 3 reported a positive learning experience on the ward and they felt well supported.

The endoscopy unit had a practice development nurse who ensured that staff completed the necessary training and had the right skills and competencies. There were four nurse endoscopists working on the unit.

Junior doctors we spoke with said they received regular teaching sessions to improve their knowledge and skills and were able to take study leave appropriately.

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

Although the appraisal target was not met for all staff in the data below, we found on inspection that all staff we spoke with had completed an appraisal in the last year. Compliance with appraisal completion was high on the wards we visited. Senior ward sisters kept a record of the compliance for their ward. For example, compliance on ward 17 (cardiology) was 100%, Ward 3 (elderly medical assessment unit) was 97.5% and ward 6 (Stroke and neurology) was 90%.

Appraisal rates

From August 2018 to July 2019, 91.4% of staff within medicine at the trust received an appraisal compared to a trust target of 95% by December each year.

Trust level

Staff group	August 2018 to July 2019				
	Staff who received an appraisal	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Add Prof Scientific and Technic	2	2	100.0%	95%	Yes
Allied Health Professionals	114	120	95.0%	95%	Yes
Additional Clinical Services	264	287	92.0%	95%	No
Nursing and Midwifery Registered	359	395	90.9%	95%	No
Administrative and Clerical	176	194	90.7%	95%	No
Medical and Dental	13	15	86.7%	95%	No
Estates and Ancillary	6	7	85.7%	95%	No

Bradford Royal Infirmary

Staff group	August 2018 to July 2019				
	Staff who received an appraisal	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Add Prof Scientific and Technic	2	2	100.0%	95%	Yes
Allied Health Professionals	88	90	97.8%	95%	Yes
Additional Clinical Services	254	274	92.7%	95%	No
Nursing and Midwifery Registered	319	351	90.9%	95%	No
Administrative and Clerical	149	164	90.9%	95%	No
Estates and Ancillary	6	7	85.7%	95%	No
Medical and Dental	11	13	84.6%	95%	No
Healthcare Scientists	9	12	75.0%	95%	No

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

Multidisciplinary working

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

Staff held regular and effective meetings to discuss patients and improve their care.

Staff spoke positively about multidisciplinary team (MDT) working and said they had good working relationships between professions.

We saw good examples of MDT working. We observed a multidisciplinary meeting on ward 6 (stroke and neurology) which was attended by the consultant, the senior sister, discharge co-coordinator, physiotherapist and occupational therapist. The meeting was effective with all professionals working together to achieve the best outcome for the patients discussed.

Daily MDT board rounds were held on the wards 29 and 31 (elderly care),

Specialist nurses were available to offer advice and support for patients with complex medical problems. For example, there were two specialist nurses for chronic obstructive pulmonary disease (COPD) and three specialist oncology nurses. Staff on ward 17 (cardiology) worked closely with specialist nurses in the community.

We saw that involvement from the MDT was documented in patients notes. This included input from the dietitian, physiotherapist, speech and language therapist and the occupational therapist.

The virtual ward was a multidisciplinary team of consultants, physiotherapists, pharmacists, nurses, occupational therapists and health care assistants. The team worked together to provide a step-down model with a ‘discharge to assess’ approach. The team linked to the elderly medical assessment unit at the hospital.

Referral pathways were in place for referral to the speech and language therapist, podiatrist and dietitian. Pharmacist and pharmacy technicians supported wards.

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. Staff told us that the trust had good working relationships with staff working in local community mental health services and with both the inpatient and community mental health services for older people.

Seven-day services

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

Consultants led daily ward rounds on all wards, including weekends. Patients were reviewed by consultants depending on the care pathway. Consultants in the acute medical units conducted ward rounds between 8am to 8.30am and again at 3pm for any new admissions.

Staff told us they had good access to diagnostics and could request diagnostic tests, 24 hours a day, seven days a week.

The service had access to 24-hour mental health liaison and other specialist mental health support if needed. A psychiatric liaison service operated from 7am to 9pm seven days a week. Out of hours cover was provided by the crisis service operated by the local mental health trust.

The critical care outreach team was available to offer support seven days a week between the hours of 7.30am and 6.30pm. This included bank holidays. In addition, there was a clinical site team consisting of two registered nurses (matron and senior sisters), clerical support and health care

support workers. The team were based at the command centre and released time to care in the transfer and allocation of patients twenty-four hours a day, seven days a week.

The oncology/haematology service had a seven day 24-hour patient helpline. Calls were triaged by nursing staff using a standard triage tool to assess whether the patient needed to be admitted to the hospital.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support on wards/units.

We saw health promotion information displayed on the wards and around the hospital. For example; information on stopping smoking, local alcohol services, health screening, dementia, carers support and falls prevention. Information on a low salt diet was displayed on notice boards ward 15 (renal unit).

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. This included advice and support on smoking cessation and alcohol intake.

Since January 2019 the hospital was a smoke free site. Patients, visitors and staff were not permitted to smoke in the hospital building or grounds

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used measures that limit patients' liberty appropriately.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. We saw that staff clearly recorded consent in the patients' records.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions.

Staff demonstrated a good understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff were able to describe how they used the Mental Capacity Act in practice.

Staff implemented Deprivation of Liberty Safeguards in line with approved documentation. We reviewed three records of patients who were subject to Deprivation of Liberty Safeguards. In all three cases staff had completed a capacity assessment and recorded decisions made in the patients' best interest.

Mental Capacity Act and Deprivation of Liberty Safeguards training completion

Trust level

The trust set a target of 85% for completion of Mental Capacity Act (MCA) training.

The trust did not supply training data regarding DOLS training modules.

A breakdown of compliance for MCA training courses from April 2018 to March 2019 at trust level for qualified nursing staff in medicine is shown below:

Training module name	April 2018 to March 2019				
	Eligible staff	Staff trained	Completion rate	Trust target	Met (Yes/No)
Mental Capacity Act Level 1	217	217	100.0%	85%	Yes
Mental Capacity Act Level 2	219	206	94.1%	85%	Yes

(Clinical) staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

In medicine the target was met for both the MCA training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 at trust level for medical staff in medicine is shown below:

Training module name	April 2018 to March 2019				
	Eligible staff	Staff trained	Completion rate	Trust target	Met (Yes/No)
Mental Capacity Act Level 1	65	64	98.5%	85%	Yes
Mental Capacity Act Level 2	66	60	90.9%	85%	Yes

In medicine the target was met for both the MCA training modules for which medical staff were eligible.

Bradford Royal Infirmary

The trust set a target of 85% for completion of Mental Capacity Act (MCA) training.

A breakdown of compliance for MCA training courses from April 2018 to March 2019 at trust level for medical staff in medicine is shown below:

Training module name	April 2018 to March 2019				
	Eligible staff	Staff trained	Completion rate	Trust target	Met (Yes/No)
Mental Capacity Act Level 1	160	160	100.0%	85%	Yes
Mental Capacity Act Level 2	163	152	93.3%	85%	Yes

In medicine the target was met for both the MCA training modules for which qualified nursing staff were eligible.

A breakdown of compliance for MCA training courses from April 2018 to March 2019 at trust level for medical staff in medicine is shown below:

Training module name	April 2018 to March 2019				
	Eligible staff	Staff trained	Completion rate	Trust target	Met (Yes/No)
Mental Capacity Act Level 1	53	53	100.0%	85%	Yes
Mental Capacity Act Level 2	53	49	92.5%	85%	Yes

In medicine the target was met for both the MCA training modules for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Is the service caring?

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Staff wore a blue badge with the message 'tell me how your care was today' to encourage conversations with patients about their care.

Patients said staff treated them well and with kindness. We spoke with 10 patients and relatives during the inspection and all were happy with the standard of care they received. Patients had drinks available and call bells located within easy reach. We saw staff maintained patient's privacy and dignity by closing curtains when providing personal care.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

There were separate male and female toilets and bathrooms on wards and separate male and female waiting areas and toilets in the endoscopy unit to ensure that patients' privacy and dignity was maintained.

Friends and Family test performance

The Friends and Family Test response rate for medicine at the trust was 31% which was better than the England average of 24% from July 2018 to June 2019.

A breakdown by site is shown below:

Site	Response rate
Bradford Royal Infirmary	30%
St Luke's Hospital	34%
Trust total	**31%**

A breakdown by ward together with the percentage of recommendations is shown below:

Ward name	Total Resp[1,2]	Resp. Rate	Percentage recommended[3]												Annual perf[1]
			Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	
Ward 3 Elderly	1,393	50%	86%	79%	96%	85%	85%	86%	86%	86%	83%	92%	90%	90%	86%
Ward 9	1,058	45%	90%	98%	98%	91%	94%	100%	100%	98%	96%	97%	96%	95%	96%
Ambulatory Care Unit / Day Care	972	30%			100%	82%		75%	100%	38%	93%	99%	95%	100%	96%
Ward 4 Acute Medical Unit	820	58%		100%	100%	100%	100%	100%	100%	96%	99%	96%	99%	96%	98%
COR2 Day Care Unit	705	9%	100%	99%	99%	97%				99%	99%	99%	100%		99%
Ward 22 Cardiology	688	57%	100%	100%	99%	100%	97%	100%	98%	100%	98%	97%	97%	97%	98%
Ward 29 Elderly	615	93%	91%	79%	91%	87%	86%	86%	100%	100%	100%	100%	100%	100%	94%
Ward 31 Elderly	528	72%	82%	76%	85%	63%	63%	47%		82%	98%	90%	84%	91%	80%
Acute Medical Unit	431	63%						100%	93%	100%	95%	99%	99%	99%	98%
Ward 15 Renal Ward	418	89%	91%	97%	93%	100%	98%	100%	97%	96%	93%	100%	100%	100%	97%
Ward F6 (St Luke's)	368	97%		97%	95%	97%	97%	97%	100%	97%	96%	94%	97%	100%	97%
Ward 23 Respiratory Medicine	348	45%	96%	100%	100%	100%	100%	100%	100%	98%	100%	98%	100%	100%	97%
Endoscopy 3	321	56%												99%	99%
Ward 6 ASNU (Acute Stroke &	315	38%	100%	95%	100%	97%	100%	100%	95%	96%	96%	94%	95%	98%	97%
Ward F5 (St Luke's)	306	81%	100%	97%	96%	100%	100%	100%	100%	100%	100%	100%	100%		99%
Ward 24 Acute Oncology	253	43%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Ward 22 Cardiology Day Care	215	23%	100%		100%	100%	100%		95%	100%	100%	100%	100%	100%	100%
Ward 33 Haematology	215	48%	100%	100%	100%	100%	100%	93%	92%	100%	100%	100%	100%	100%	99%
Ward 7 Acute Medical Ward	205	47%	100%	94%		86%	100%	100%	95%	94%	93%	100%	95%	95%	96%

Key: Highest score to lowest score — 100% | 50% | 0%

1. The total responses exclude all responses in months where there were less than five responses at a particular ward (shown as gaps in the data above), as well as wards where there were less than 100 responses in total over the 12 month period.
2. Sorted by total response.
3. The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard.

(Source: NHS England Friends and Family Test)

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. We saw a range of thank you cards from patients and relatives displayed on ward notice boards. Comments were positive and thanked the staff for their kindness and for supporting them in difficult times.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Patients we spoke with told us that although staff were busy they were able to give them time to talk if they were upset and needed support.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. A patient we spoke with told us that they had been given bad news about their prognosis and staff had discussed this with them sensitively and provided them with the support they needed.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity.

A multi-faith chaplaincy service was available to offer spiritual and pastoral care to patients and relatives 365 days a year. A prayer room with ablution facilities and a quiet room was available at the hospital for people of all faiths to use. Information on this service was displayed in ward areas.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. Patients said they had an opportunity to ask questions and felt confident in their responses from staff. The wards worked with relatives, other services and staff to organise and manage discharges.

A relative of a patient on the hyper acute stroke unit told us they had plenty of opportunities to speak with doctors and nurses about plans for their relative and they had no complaints about the care provided.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. We observed staff taking time to talk to patients and explaining to them clearly what their plan of care was.

Wards had extended visiting hours to allow relatives and those close to patients to visit throughout the day. We saw relatives comforting distressed patients and assisting them with their meals.

The hospital had displays boards which identified the roles of staff and the uniforms they wore to help patients and relatives understand their roles.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Is the service responsive?

Service delivery to meet the needs of local people

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

Managers planned and organised services, so they met the changing needs of the local population. The trust worked closely with the local clinical commissioning groups other agencies and providers to meet the needs of the population. There was joint working with a neighbouring acute NHS trust for some medical specialities to provide a co-ordinated approach across the patch. For example, the stroke service was working in collaboration with Airedale to share resources, joint recruitment campaigning and planning. Meetings were held to discuss strategic aims for stroke.

Facilities and premises were appropriate for the services being delivered.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems. The trust had a service level agreement with another trust which specialised in mental healthcare. The service level agreement provided a psychiatric liaison service with staff from a background in mental healthcare to work within the trust's accident and emergency department and to provide in-reach into the trust's medical wards.

Systems were in place to aid the delivery of care to patients in need of additional support. For example, patients with a learning disability or dementia were flagged on the trust's electronic system to highlight additional support that may be required.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. During our inspection we found no mixed sex accommodation breaches.

Meeting people's individual needs

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

At the time of our inspection the hospital did not have a dedicated nurse for learning disabilities, however, a business case had been approved and recruitment was underway. The safeguarding adults team provided support for patients with a learning disability and there was an honorary contract with the health facilitation team based at the local mental health trust who attended wards to offer support and guidance. The trust used 'closing the gap' documentation for patients with a learning disability which gave staff information about the patient, including their likes and dislikes and how they preferred to communicate. We saw this was in place for a patient being cared for on a medical ward during the inspection.

Elderly care wards were designed to meet the needs of patients living with dementia. The wards we visited had dementia friendly adaptations in place including pictures on toilets and bathroom doors. Televisions were available on wards which showed old black and white films for patients living with dementia to watch. The trust was making changes to the documentation used for patients with dementia and were replacing the 'see who I am' document to the "this is me" document. to support the personalised assessment and care planning for patients with dementia. There was a lead nurse for dementia and an enhanced care team was available to provide patients who were agitated with activities to distract and entertain them.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. There was a flagging system within the electronic patient record and all patients with a sensory loss have a flag added to their record. This was carried out as part of the initial assessment and then pulled through to each subsequent admission. Patient information was available in a variety of formats to adhere to the accessible information standard. A text service was available for patients with hearing difficulties and British sign language interpreters could be provided.

The service had information leaflets available in languages spoken by the patients and local community. Access to interpreters was available when needed. The trust had developed a tool to enable staff to give patients information using pictures rather than words which could be used with patients whose first language is not English. This initiative had won a national Health Service Journal award.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

Access and flow

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

The trust had launched a new electronic system to improve efficiency and patient flow through the hospitals. The system was developed in conjunction with an external company and was bespoke to the trust's requirements. The system produced a wall of analytics that constantly pulled in streams of data from the trust's electronic patient record system and from many other separate sources of data from across the hospitals. The analytics wall was based at the command centre and provided staff with real-time information over 24-hours, seven days a week, to enable them to make informed decisions on managing patient flow across the hospitals. In addition, the system included a facility to alert porters and domestic staff when a patient needed moving and a bed space needed cleaning in

preparation for another patient. There were plans in place to develop the system further which would go live in 2020.

Patient flow was discussed at daily bed meetings which were held at 9am, 1pm and 3.30pm. Bed meetings were attended by the command centre manager, the patient flow matron, matrons and managers from different areas across the hospital. We attended a patient flow meeting at the trust and saw the meeting was well run with patient flow, outliers and staffing discussed. There were a number of surge beds available if these were required when demand for beds was high.

All patients were given a provisional discharge date on admission and this was updated to an estimated discharge date (EDD) by the consultant. The EDD was reviewed daily to identify any barriers to this being achieved.

The virtual ward service was provided by an integrated multidisciplinary team which aimed to prevent unnecessary admissions and facilitate early discharge of patients from the acute hospital into the community. The team supported frail elderly patients to avoid admissions or to be discharged swiftly and effectively without the need for readmission.

Patients over the age of 77 years old could be admitted directly onto ward 3 (elderly medical assessment unit). The ward also accepted patients from the emergency department. Staff told us that patients' normal length of stay on this ward was 24 – 48 hours. The ward worked closely with the virtual ward to ensure patients did not stay in hospital longer than they needed to. Those requiring further treatment were moved to a speciality ward.

Staff on wards 29 and 31 were piloting the use of the SAFER patient flow bundle to reduce delays and improve patient flow. SAFER involved all patients on the ward having a senior medical review before midday, all patients being allocated an expected discharge date, discharge to take place early in the day and a multidisciplinary review of patients with extended stay. Staff told us the plan was to roll SAFER out to other wards in the hospital following the pilot.

Staff could refer patients requiring a complex discharge to the multi-agency integrated discharge team (MAIDT). The team worked with other agencies to facilitate and co-ordinate a safe and timely discharge of patients from the hospital. They liaised with other agencies including community services, social care providers, carers and relatives to devise a multi-agency plan.

The trust had processes in place to ensure that patients being treated on wards that weren't specialist to medicine (medical outliers) were seen daily by a named medical consultant or their registrar. Between the period 1 September to 30 November 2019 the number of medical outliers ranged from seven a day to 41. During our inspection we reviewed an outlier report which listed all medical patients on non-medical wards. We checked the records of five patients and found that each had been reviewed daily with medical and nursing notes updated and a plan of care with next steps in place.

The hospital had a clear escalation and winter plan to help them deal with extra demand over winter months. The plan included opening additional beds across several different wards rather than accommodating all surge beds within one ward.

Average length of stay

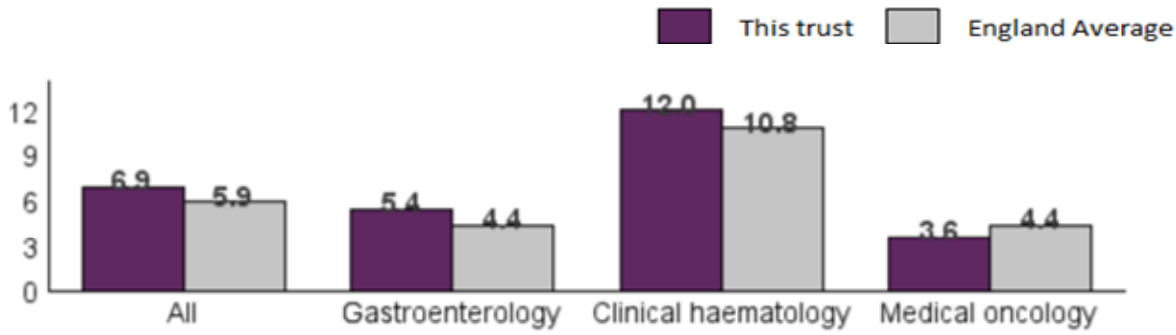
Trust Level

From March 2018 to February 2019 the average length of stay for medical elective patients at Bradford Teaching Hospitals NHS Foundation Trust was 6.9 days, which was higher than the England average of 5.9 days. For medical non-elective patients, the average length of stay was 4.5 days, which was lower than the England average of 6.1 days.

Average length of stay for elective specialties:

- Average length of stay for elective patients in gastroenterology and clinical haematology was higher than the England average.
- Average length of stay for elective patients in medical oncology was lower than the England average.

Elective average length of stay – Trust level

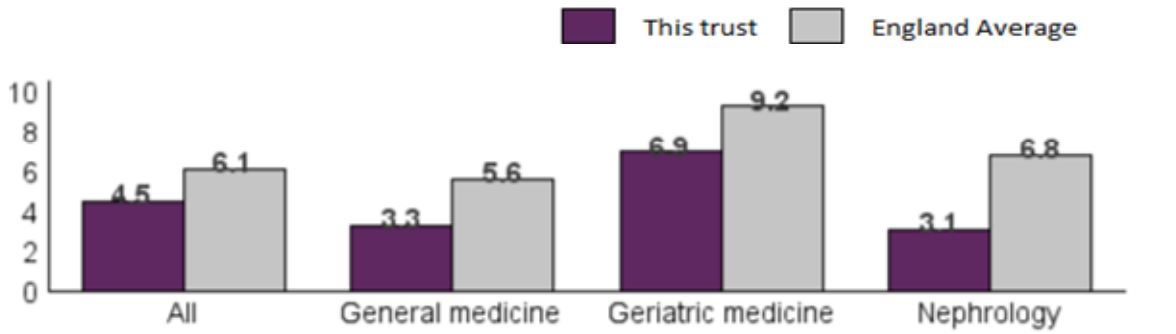


Note: Top three specialties for specific trust based on count of activity.

Average length of stay for non-elective specialties:

- Average length of stay for non-elective patients in general medicine, geriatric medicine and nephrology was lower than the England average.

Non-elective average length of stay – Trust level



Note: Top three specialties for specific trust based on count of activity.

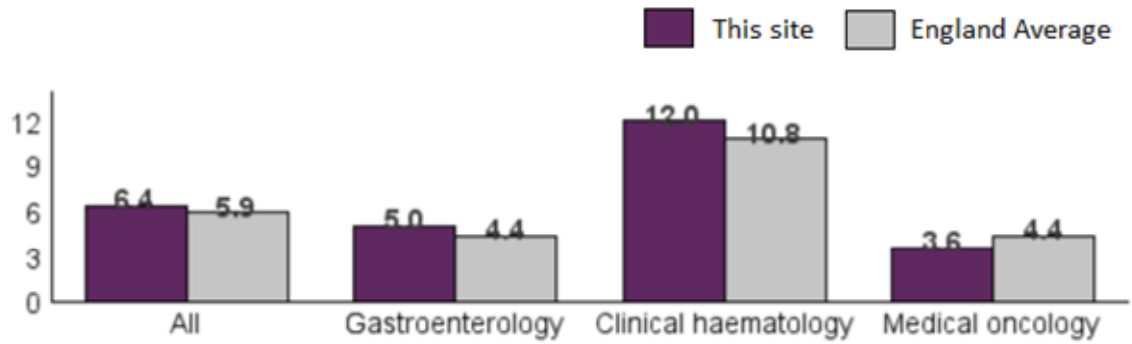
Bradford Royal Infirmary

From March 2018 to February 2019 the average length of stay for medical elective patients at Bradford Royal Infirmary was 6.4 days, which was higher than England average of 5.9 days. For medical non-elective patients, the average length of stay was 3.7 days, which was lower than England average of 6.1 days.

Average length of stay for elective specialties:

- Average length of stay for elective patients in gastroenterology and clinical haematology was higher than the England average.
- Average length of stay for elective patients in medical oncology was lower than the England average.

Elective average length of stay - Bradford Royal Infirmary

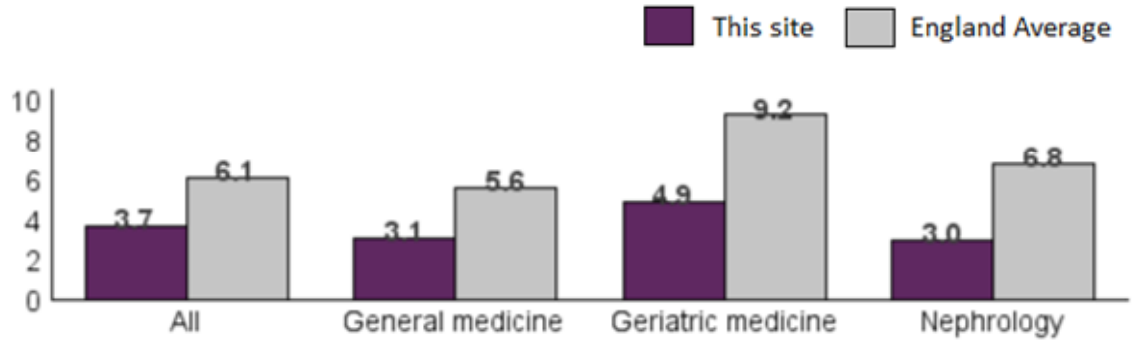


Note: Top three specialties for specific site based on count of activity.

Average length of stay for non-elective specialties:

- Average length of stay for non-elective patients in general medicine, geriatric medicine and nephrology was lower than the England average.

Non-elective average length of stay - Bradford Royal Infirmary

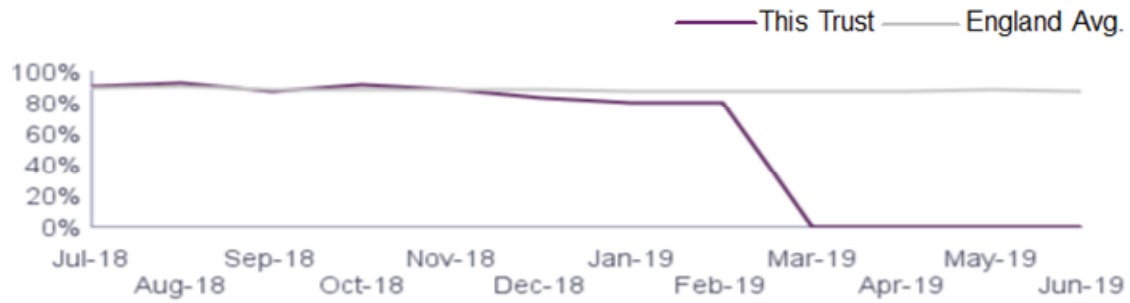


Note: Top three specialties for specific site based on count of activity.

(Source: Hospital Episode Statistics)

Referral to treatment (percentage within 18 weeks) - admitted performance

From July to November 2019, the trust's referral to treatment time (RTT) for admitted pathways for medicine was about the same as the England average. Performance declined from December 2018 to February 2019 to below the England average. Data from March 2019 has not been submitted.



(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – by specialty

The following three specialties were above the England average for admitted RTT (percentage within 18 weeks):

Specialty grouping	Result	England average
Geriatric medicine	100.0%	96.7%
Thoracic medicine	98.6%	94.2%

Dermatology	90.0%	80.9%

The following five specialties were below the England average for admitted RTT (percentage within 18 weeks):

Specialty grouping	Result	England average
Rheumatology	90.0%	94.8%
Gastroenterology	89.3%	92.5%
Cardiology	75.7%	80.8%
Neurology	62.5%	88.8%
General medicine	58.3%	96.6%

(Source: NHS England)

Updated information below shows the RTT position for December 2019. Overall as of December 2019 the RTT figures for medicine was 88% which was similar to the England average of 87%.

Speciality	Performance	Trust end of year target
Dermatology	91.1%	92.0%
Diabetic Medicine	96.3%	95.0%
Endocrinology	93.4%	95.0%
General Medicine	80.6%	100.0%
Geriatric Medicine	98.7%	100.0%
Haematology	86.5%	92.0%
Nephrology	94.6%	95.0%
Neurology	77.9%	92.0%
Neurophysiology	88.9%	92.0%
Rheumatology	70.4%	92.0%
Stroke Medicine	100.0%	100.0%
Gastro & Hepatology	89.3%	92.0%
Urology	84.5%	92.0%

Patient moving wards per admission

The trust did not provide this information in the provider information request.

(Source: Routine Provider Information Request (RPIR) – Ward moves tab)

Patient moving wards at night

From August 2018 to July 2019, there were 13 patients moving wards at night within medicine at Bradford Royal Infirmary.

(Source: Routine Provider Information Request (RPIR) – Moves at night tab)

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. A 'Tell us what you think' booklet was available for patients and relatives which gave information on how to provide feedback to the service and how to make a complaint. Information on how to make a complaint was also available on the trust website.

Staff understood the policy on complaints and knew how to handle them. Staff told us they always tried to deal with any concerns from patients or relatives locally before they escalated into a complaint.

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

Managers investigated complaints and identified themes. Feedback from complaints was shared with staff and learning was used to improve the service. For example, on ward 17 and ward 23 there had been some complaints about noise levels at night and poor communication. The senior sister had shared these complaints with staff to raise their awareness and make improvements. Posters were displayed to remind staff about keeping noise to the minimum at night and patients were offered ear plugs.

Medical staff on ward 31 told us that learning from complaints was shared with staff at the daily multidisciplinary meetings.

We reviewed a complaint made to the service and found that a thorough and fair response was provided, and an action plan was formed to ensure that the learning from the complaint was shared with staff.

Summary of complaints

Trust level

From August 2018 to July 2019, the trust received 167 complaints about medicine (31.9% of total complaints received by the trust). The trust took an average of 59.5 working days to investigate and close complaints. Trust policy was to provide a written response to complainants following an investigation into the issues raised within either 30 or 60 working days, depending on the complexity of the complaint. In some circumstances where complaints were more complex, different timescales were agreed with the complainant to respond to their concerns, within a maximum period of 6 months.

A breakdown of complaints by type is shown below:

Type of complaint	Number of complaints	Percentage of total
General Medicine Group	52	31.1%
Patient Care including Nutrition/Hydration	26	15.6%
Appointments including delays and cancellations	18	10.8%
Admissions, discharge and transfers (excluding delayed discharge due to absence of care package)	15	9.0%
Clinical Oncology	14	8.4%
Surgical Group	10	6.0%
Communications	8	4.8%
Values and Behaviours (Staff)	6	3.6%
End of Life Care	5	3.0%
Accident and Emergency	4	2.4%
Prescribing errors	2	1.2%
Access to treatment or drugs (including decisions made by	2	1.2%

Commissioners)		
Transport (Ambulances only)	1	0.6%
Trust Administration	1	0.6%
Mortuary and post-mortem arrangements	1	0.6%
Privacy, dignity and wellbeing	1	0.6%
Obstetrics and Gynaecology	1	0.6%
Total	**167**	**100.0%**

Out of these 167 complaints in relation to medicine, 149 (89.2%) referred to Bradford Royal Infirmary and 18 (10.8%) referred to St Luke's Hospital.

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Number of compliments made to the trust

From August 2018 to July 2019, there were 239 compliments relating to medicine at the trust.

A breakdown of compliments by site is below:

Site	Number of compliments	Percentage of total
Bradford Royal Infirmary	212	88.7%
St Luke's Hospital	27	11.3%
Total	**239**	**100.0%**

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Is the service well-led?

Leadership

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

The trust had moved to a new clinical operations structure in April 2019 and had implemented a clinical business unit (CBU) model. The CBUs were configured to reflect patient pathways and allowed managers and clinical leaders to work closely together to deliver services.

The CBUs sat under two overarching care groups (planned and unplanned care). The majority of medical care services were provided under the unplanned care group within three CBUs. These were CBU 9 (urgent and emergency care), CBU 11 (elderly and intermediate care) and CBU 13 (specialised medicine).

Each ward had a matron to provide strategic and managerial support and a senior ward sister (Band 7) to manage the ward. Senior ward sisters spoke highly of their matrons and said they received good support and spoke with them daily.

One senior sister told us they had been in post less than a year and had initially felt under supported in their new role. This had been recognised and acknowledged and they were now receiving much better support including being mentored by another senior sister.

Staff told us that the chief nurse visible and there was good support from senior nurses in the organisation.

Staff on ward 23 told us that there had been many improvements on the ward in since the appointment of a new senior sister. Since the change in ward leadership staff morale had improved and staff sickness had reduced.

Leaders recognised the benefits of investing in the development of staff and this was encouraged. The trust provided a leadership development programme for wards sisters and senior sisters.

Vision and strategy

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

The trust vision was to be 'an outstanding provider of healthcare, research and education'. The trust had a clinical services strategy for 2017-2022. The strategy was shaped around four themes; high quality care, research-led care and learning, collaborative hospital care and connected local care.

The trust worked to a set of values of;

- we care,
- we value people,
- we strive for excellence
- we make every penny count

There was no overarching strategy for medical services, however, to accommodate the trust's move to a CBU operational structure, individual service development plans were being developed. The plans took account of the trust's clinical service strategy, the NHS Long Term Plan and the Model Hospital. These plans set out the service development intentions for each medical specialty and were a key component to deliver the overarching trust clinical service strategy.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

We found a positive culture in medical care services. Staff were proud of their services and focused on providing the best care they could to patients.

We found staff to be highly motivated and focussed on patient care and development of the service. We saw that staff spoke with each other and patients in a respectful way. This included staff at all management levels to staff delivering care.

Morale was generally good, and staff spoke positively about recent changes and improvements to services for patients.

Senior ward sisters told us they were proud of their teams and the care they provided for patients.

Staff told us there was an open culture and they were encouraged to raise concerns. Staff felt listened to and managers were open to ideas staff put forward to improve services.

Senior managers and clinical leaders said they always tried to demonstrate good behaviour by treating staff with kindness and respect. They felt it was important to be a good role model to junior staff.

Governance

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

Each CBU held regular clinical governance meetings. Due to the number of specialities within specialised medicine CBU, each speciality held its own clinical governance meetings. Governance meetings were held every six weeks to eight weeks. Agenda items included incidents, safety alerts, audit performance, complaints, risks and staffing. Items for escalation were discussed and documented and if necessary escalated to the planned care group governance meetings, which in turn were fed up to the patient safety subcommittee and the board. However, we reviewed the minutes of several specialities and found that they varied in quality and content. Some meetings did not include a list of attendees and did not have clear comprehensible minutes which could be understood by those not able to attend.

The acute medical units were managed within the urgent and emergency care CBU. Governance was discussed across several meetings on a monthly or weekly basis. This included the urgent care delivery board, the urgent care improvement board, breach review meetings, budget and contracting meetings, weekly risk huddles and senior leadership team meetings. The CBU used the format of the trust scorecard as a structure for recording governance issues and this was formally reported to the director of operations monthly.

Wards did not always have regular staff meetings however; the senior sisters produced a communication bulletin to cascade information to their teams which staff were required to sign to show they had read the contents. We saw evidence that staff received feedback through weekly learning newsletters they received information via emails, newsletters, at handover and when they attended safety huddles.

Management of risk, issues and performance

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

Senior ward sisters could articulate their greatest risks and were clear on how to escalate risks to the matron. Risk was discussed at monthly governance meetings and items of greatest concern were escalated to the unplanned care group leaders. Service leads were also sighted on their greatest risks. We reviewed the risk register for the unplanned care group and found it contained 31 risks. The highest risks were the capacity of the endoscopy unit and nurse staffing particularly on ward 6 and ward 23. Other risks we identified during the inspection were included. We saw that the register included control measures, mitigation, summaries of mitigation and target and review dates.

Care Groups and CBUs used a balanced scorecard which was aligned to the trust integrated dashboard. They used the scorecard to review, measure and manage their performance. We reviewed the scorecard for the unplanned care group and found it provided a comprehensive set of data to enable managers to review the performance of their services against key performance indicators and identify areas of concern. Data included harm free care, patient experience, workforce, finance, activity, productivity and operational performance. The scorecard included actions which were being taken when performance was not satisfactory.

Staff contributed to regular meetings to discuss cost improvement measures.

Information management

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

The trust aimed to become a national digital exemplar using the data held within the electronic patients record to drive quality improvement and applied health research.

The service used a wide variety of data and used it to plan, measure and manage their services. This included the balanced scorecard, ward heat maps and information on the electronic records system and electronic prescribing system.

The trust had launched a new electronic system to improve efficiency and patient flow through the hospitals. The system produced a wall of analytics that constantly pulled in streams of data from the trust's electronic patient record system and from many other separate sources of data from across the hospitals. The analytics wall was based at the command centre and provided staff with real-time information over 24-hours, seven days a week, to enable them to make informed decisions on managing patient flow across the Trust's hospitals. There were plans to expand the system to include several other information streams, for example a deteriorating patient tile.

Staff told us the intranet was easy to navigate and they could find training information and access e-learning. Ward managers had access to electronic staff records so they could view appraisal, sickness and training rates.

There were arrangements in place for submitting data and notifications to external bodies.

Engagement

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

The service measured and monitored staff and patient engagement through national and local satisfaction surveys, patient experience information panels and patient stories. Feedback from comments, concerns, compliments and complaints from individual service users and members of the public were used to shape services.

People using the service were encouraged to give their opinion on the quality of service they received. The service used the Friends and Family Test to collect patients views on the care they had received. Comment cards 'Tell Us What You Think' were used throughout the trust.

Staff attended local groups in community to gather feedback and used this to improve services. For example, feedback from the 'facing it together' group of the Alzheimer's Society resulted in a project to implement blue wristbands for patients with dementia.

Managers engaged well with staff. There were a number initiatives to recognise and reward individual staff and team performance. We saw 'certificate of appreciation', 'star of the week' and 'employee/team of the month' awards displayed on ward notice boards.

Staff were consulted on change and were involved in new developments. For example, staff had been consulted on the design of the new analytics wall based in the command centre. We found staff to be engaged and this was reflected in the results of the staff survey which showed that staff engagement and morale were above average.

Learning, continuous improvement and innovation

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

We found that staff at all levels were engaged with service development and improvement. Staff told us about service improvement projects they were currently undertaking and projects they were planning to do. Staff told us that senior sisters were open to improvement ideas and they were supported to take them forward.

One ward was trialling the role of the healthcare coordinator as part of a quality improvement project. The role encouraged staff to lead the ward safety huddle as well as becoming better informed.

Staff on wards 29 and 31 were piloting the use of the SAFER patient flow bundle to reduce delays and improve patient flow. This was planned to be rolled out to other wards using the lessons learnt from the pilot.

A virtual diagnostic ward was being introduced which enabled patients to be discharged from in-patient care and receive diagnostics in the community and to the same timescale as if they were still an in-patient.

The elderly virtual ward was an innovative service which provided integrated, multidisciplinary person-centred care, planning and support for people aged 65 and over with complex care needs. The team of multidisciplinary team of clinical staff including nursing, therapy and medical staff, provided responsive assessment, monitoring, investigations, support and education to frail elderly patients. The service had been successful in preventing admissions and facilitating early discharge from the hospital.

Managers produced a quarterly ‘learning matters’ newsletter which included statistics on the number of adult deaths and how many had a mortality review. It highlighted good practice, practice requiring improvement and key recommendations for staff. The newsletter was displayed in clinical areas and circulated to all staff.

Maternity

Facts and data about this service

Bradford Teaching Hospitals NHS Foundation Trust's maternity services are provided at Bradford Royal Infirmary where the following services are offered:

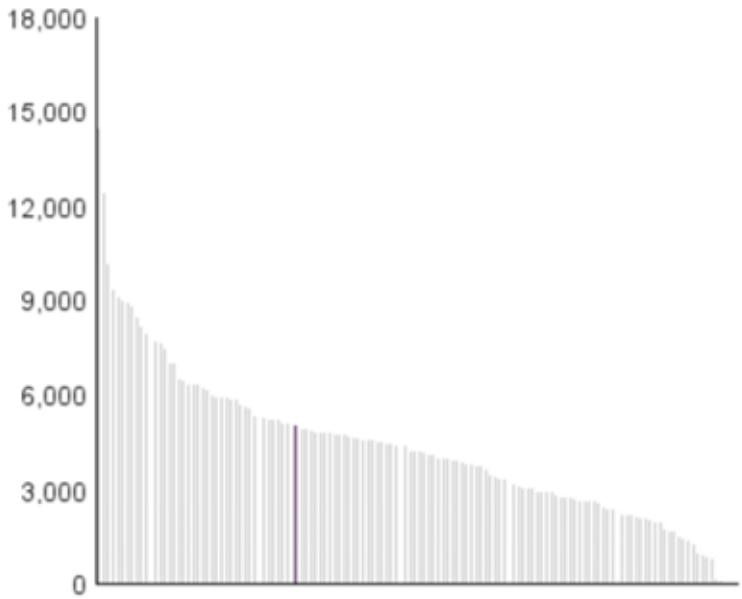
- A four bedded Maternity Assessment Centre provides a 24-hour service, triaging and assessing women from 16 weeks of pregnancy onwards. A four bedded antenatal day unit is open five days a week (9am - 5pm).
- The labour ward has 13 beds including a bereavement suite and a high dependency room.
- There are two obstetric theatres and two recovery beds.
- Bradford birth centre has seven labour beds providing care for low risk women.
- The maternity service has one antenatal/postnatal ward (ward M3) and one postnatal/transitional care ward (ward M4). Ward M3 has 20 antenatal beds and an eight bedded co-located Induction of Labour Suite. Ward M4 has 20 postnatal beds and a nine bedded co-located transitional care unit.
- There are ten community teams providing antenatal and post-natal care.

(Source: Trust Provider Information Request – RPIR Acute – AC1. Context Acute)

From January 2018 to December 2018 there were 4,960 deliveries at the trust. However, this figure did not included data where delivery method was 'other' or 'unrecorded'. Staffing papers presented to the trust board detailed that there were 5,387 deliveries in the 2018 calendar year.

A comparison from the number of deliveries at the trust and the national totals during this period is shown below.

Number of deliveries at Bradford Teaching Hospitals NHS Foundation Trust – Comparison with other trusts in England.



(Source: Hospital Episode Statistics (HES))

A profile of all deliveries and gestation periods from January 2018 to December 2018 can be seen in the tables below. The trust has a younger profile and a slightly higher single birth percentage when compared to England percentages:

Profile of all deliveries (January 2018 to December 2018)			
	Bradford Teaching Hospitals NHS Foundation Trust		England
	Deliveries (n)	Deliveries (%)	Deliveries (%)
Single or multiple births			
Single	4,915	99.1%	98.6%
Multiple	45	0.9%	1.4%
Mother's age			
Under 20	230	4.6%	3.0%
20-34	3,915	78.9%	74.6%
35-39	680	13.7%	18.5%
40+	135	2.7%	4.0%
Total number of deliveries			
Total	4,960		581,697

Notes: A single birth includes any delivery where there is no indication of a multiple birth. This table does not include deliveries where delivery method is 'other' or 'unrecorded'.

To protect patient confidentiality, figures between 1 and 7 have been suppressed and replaced with "" (an asterisk). Where it was possible to identify numbers from the total due to a single suppressed number in a row or column, an additional number (generally the next smallest) has also been suppressed. Values greater than 7 rounded to the nearest 5 with the delivery rate calculated with the rounded figures. This does not apply to the 'other/unrecorded' method of delivery as patients are not identifiable.*

At Bradford Teaching Hospitals NHS Foundation Trust, gestation periods were unrecorded for 51.9% of deliveries compared to 18.7% nationally from January 2018 to December 2018.

Is the service safe?

Mandatory training

The service provided mandatory training in key skills to all staff; and overall mandatory training compliance figures exceeded trust targets. Managers monitored mandatory training; however, the electronic system (database) did not allow them to easily identify and alert staff when they needed to update their training. Compliance rates for mandatory obstetric emergency training and cardiotocography (CTG) training were above service targets.

Mandatory training completion rates

The service provided mandatory training to all staff; however, not all staff completed it.

The trust set two different targets of 85% and 95% for completion of mandatory training. These targets were dependant on individual modules.

Mandatory training completion rates – nursing and midwifery staff

A breakdown of compliance for mandatory training courses from April 2018 to March 2019 at trust level for qualified nursing staff in maternity is shown below:

Training module name	April 2018 to March 2019				
	Eligible staff	Staff trained	Completion rate	Trust target	Met (Yes/No)
Infection Control - No Renewal	213	213	100.0%	85%	Yes
NEWS/PAWS/Neo-Nate Observation Theory General	11	11	100.0%	85%	Yes
Corporate Induction	213	213	100.0%	85%	Yes
Mental Capacity Act Level 1	187	186	99.5%	85%	Yes
Communication Improvement using	206	203	98.5%	85%	Yes

the SBAR Technique General					
Introduction to Equality & Diversity General	213	199	93.4%	85%	Yes
Mental Capacity Act Level 2	209	193	92.3%	85%	Yes
Venous Thromboembolism - No Renewal	210	190	90.5%	85%	Yes
Diabetes Care and Safe Use of Insulin General	209	185	88.5%	85%	Yes
Conflict Resolution - 3 Years	205	150	73.2%	85%	No
Infection Control - 1 Year	213	154	72.3%	85%	No
Information Governance - 1 Year	213	146	68.5%	95%	No
Blood Transfusion - 2 Years	136	89	65.4%	85%	No
Safe Administration of Medicines - Competence Assessment General	205	123	60.0%	85%	No
Safe Administration of Medicines - 2 Year	213	127	59.6%	85%	No
Moving & Handling Medium/High Risk General	206	111	53.9%	85%	No
Organising Receipt of Blood - 3 Year	137	62	45.3%	85%	No
Preparing to Administer/Administering Blood - 3 Year	174	67	38.5%	85%	No
NEWS/PAWS/Neo-Nate Observation Competence Assessment General	11	0	0.0%	85%	No

At our previous inspection of the service, we said the trust must ensure midwifery staff were compliant with all aspects of mandatory training. Following our recent inspection, we saw that overall, safeguarding mandatory training compliance figures exceeded the trust target.

Mandatory training data for the year to date (to July 2019) showed 89.8% of qualified nursing and midwifery staff in the maternity service were compliant with mandatory training for which they were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Mandatory training completion rates – medical staff

Training module name	April 2018 to March 2019				
	Eligible staff	Staff trained	Completion rate	Trust target	Met (Yes/No)
Communication Improvement using the SBAR Technique	18	18	100%	85%	Yes
Dangers of Misplaced Nasogastric (NG) Tube	11	11	100%	85%	Yes
Safe Administration and Preparation of Injectables	18	18	100%	85%	Yes
Moving & Handling Low Risk	37	37	100%	85%	Yes
Acute Kidney Injury (AKI) General	17	17	100%	85%	Yes
Corporate Induction	37	37	100%	85%	Yes
Diabetes Care and Safe Use of Insulin	18	18	100%	85%	Yes
Infection Control - No Renewal	37	37	100%	85%	Yes
Fire Safety - 2 Years	18	18	100%	85%	Yes
Introduction to Equality & Diversity	37	37	100%	85%	Yes
Health and Safety - 2 Years	37	35	95%	85%	Yes

Information Governance - 1 Year	37	33	89%	95%	Yes
Infection Control - 1 Year	18	16	89%	85%	Yes
NEWS2 Observation Theory	17	15	88%	85%	Yes
Blood Transfusion - 2 Years	18	14	78%	85%	No
Fire Safety - 1 Year	19	9	47%	85%	No

Mandatory training data for the year to date (to July 2019) showed 99% of medical staff in the maternity service were compliant with mandatory training for which they were eligible.

At inspection, senior staff informed us that adult basic life support and neonatal resuscitation training was provided as part of Practical Obstetric Multi-Professional Training (PROMPT). As of July 2019, we saw that PROMPT compliance for different staff groups within the maternity service ranged from 92% to 100% (see below for additional information).

There was an education strategy for women's services, which had last been refreshed in February 2019. It was the individual staff members responsibility to ensure they completed their mandatory training. The responsibility for attendance laid with both the individual member of staff and the line manager, who was required to release the member of staff as a priority. Managers monitored mandatory training; however, the electronic system (database) used to do this did not allow them to easily identify and alert staff when they needed to update their training. Managers described, and we observed, that the current system was cumbersome and time consuming; and did not lend itself to the easy identification of staff who required training.

Some members of staff we spoke with during our inspection described that they were not compliant with aspects of mandatory training, as they had been pulled from training courses (or training courses had been cancelled entirely) due to staffing and acuity.

Following our inspection, the service reported that four workshops had been cancelled during the 2019 calendar year; however, these had subsequently been rescheduled. The service did not comment on the numbers or proportions of individual staff members who had been pulled from training courses due to staffing and acuity.

Midwives, medical staff and healthcare assistants attended annual Practical Obstetric Multi-Professional Training (PROMPT). The training was a one-day multi-professional course to train staff in recognising the deteriorating pregnant woman and to act appropriately. Key PROMPT training topics included electronic fetal monitoring in labour, pre-eclampsia and eclampsia, maternal sepsis, maternal haemorrhage, shoulder dystocia, cord prolapse, vaginal breech birth, and life support. Training included (planned) scenario skills and drills.

There was a bespoke community obstetric emergency training programme; which was tailored to the specific needs and environments of community midwifery. The scenarios were based upon real life events and the day was held in a home setting to enable the community midwives to problem solve more realistically and effectively.

Excluding staff on long-term sickness absence, maternity leave and on career breaks, data for the period August 2018 to July 2019 showed the following levels of compliance among different staff groups within maternity services:

Maternity service staff group	**PROMPT training: August 2018 to July 2019**		
	Eligible staff*	**Staff trained**	**Completion rate**
Obstetric Consultants	17	17	100%
Junior Doctors Obstetrics	33	32	97%
Anaesthetic Consultants	12	11	92%
Junior Doctors Anaesthetics	25	24	96%

Midwives (including agency staff)	257	243	94%
Midwifery Support Staff	57	54	95%
Theatre Practitioners	22	21	95%

*****Eligible staff excluded those on long-term sickness absence, maternity leave and on career breaks.

At inspection, staff in maternity services at the hospital said that they had attended skills and drills training in the 12 months prior to our inspection; as part of PROMPT study days. Leaders responded to say that scenarios were incorporated into both the community and hospital skills days and covered a variety of obstetric/new-born emergency situations. Following our inspection, we requested impromptu or unplanned skills and drills training data for the previous 12 months. Two impromptu skills and drills had been undertaken at the service, one in November 2018 and one in July 2019.

The service provided maternal acute illness management (mAIM) training. mAIM is an enhanced maternal training course for the recognition, management and escalation of the deteriorating patient. The service reported that over 50 midwives in the hospital and community were MAIMs trained; with an ongoing programme of three to four courses offered per year.

We saw evidence of cardiotocography (CTG) training for midwifery staff. Staff completed online K2 CTG training, supported by competency-based (simulation training) assessments.

Designated staff providing intrapartum care also had to complete cord blood gas and intrapartum CTG modules and assessments. The service reported that as of January 2019, all relevant staff had completed the training. We reviewed a sample of CTG competency-based assessments on site and saw these had been appropriately completed.

Clinical staff completed training on recognising and responding to women with mental health needs, learning disabilities, autism and dementia.

The service reported two specialist midwives had received enhanced postnatal mental health (PNMH) training. Learning Disabilities training was available through mandatory adult safeguarding. In addition, leaders reported that perinatal mental health leads from the NHS community trust delivered update and refresher sessions on the annual midwifery update. Training topics covered included caring for women pre-existing mental problems, as well as those at risk of developing mental health problems during the perinatal period.

Safeguarding

Overall, safeguarding mandatory training compliance figures exceeded the trust target, and staff knew how to recognise and report abuse. However, we were not assured midwives had opportunities to regularly attend child protection conferences and submit reports to facilitate decision making and safety planning.

There were safeguarding policies in place. Policies detailed the different types of abuse, what concerns could potentially be a safeguarding concern, issues which staff should report, and how to raise concerns.

There was a trust safeguarding team responsible for child and adult protection. There were safeguarding adults and safeguarding children's steering groups, who reported to the integrated safeguarding committee. There was a named midwife for safeguarding in post at the hospital, and a midwifery safeguarding practitioner.

At our previous inspection of the service, we said the trust must ensure midwifery staff were compliant with all aspects of mandatory training. At our recent inspection, we saw staff received training specific for their role on how to recognise and report child abuse.

Compliance rates for children's safeguarding level three training was marginally below trust target for qualified nursing and midwifery staff as of March 2019. However, year to date data for July 2019 showed these had been improved, and overall compliance exceeded the trust target.

Safeguarding training completion rates

The trust set a target of 85% for completion of safeguarding training.

Safeguarding training completion rates –qualified nursing and midwifery staff

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 at trust level for qualified nursing staff in maternity is shown below:

Training module name	April 2018 to March 2019				
	Eligible staff	Staff trained	Completion rate	Trust target	Met (Yes/No)
Safeguarding Children Level 2 - 3 Years	213	211	99.1%	85%	Yes
Safeguarding Children Level 1 - 3 Years	213	211	99.1%	85%	Yes
Safeguarding Adults Level 1 - 3 Years	213	210	98.6%	85%	Yes
Safeguarding Adults Level 2 - 3 Years	213	210	98.6%	85%	Yes
Safeguarding Children Level 3 - 1 Year	212	145	68.4%	85%	No
Safeguarding Children Level 3 Specialist - 1 Year General	22	13	59.1%	85%	No

(Source: Routine Provider Information Request (RPIR) – Training tab)

Following our inspection, we saw documentation that showed 81.3% of midwives were compliant with safeguarding children level three training.

Safeguarding training data for the year to data for July 2019 showed 96% of qualified nursing and midwifery staff in the maternity service were compliant with safeguarding training for which they were eligible.

Safeguarding training completion rates – medical staff

Training module name	April 2018 to March 2019				
	Eligible staff	Staff trained	Completion rate	Trust target	Met (Yes/No)
Safeguarding Children Level 2 - 3 Years	18	18	100%	85%	Yes
Safeguarding Children Level 3 - 1 Year	17	17	100%	85%	Yes
Safeguarding Children Level 1 - 3 Years	37	37	100%	85%	Yes
Safeguarding Adults Level 1 - 3 Years	37	36	97%	85%	Yes

Safeguarding training data for the year to data for July 2019 showed 99% of medical staff in the maternity service were compliant with safeguarding training for which they were eligible.

During our inspection, senior staff reported that approximately 13% of cases (women who delivered at the trust) involved safeguarding issues. Following our inspection, the service provided information that showed from April 2018 to March 2019, the maternity services supported 597 women with a heightened level of need leading to potential safeguarding and /or child protection issues. This represented 11.1% of the total births for the year and an increase of 0.7% from last year.

From these 597 women with a heightened level of need, 178 referrals were made to children's social care (CSC) for unborn and new-born babies by maternity staff. This equated to a new referral to

CSC for 30% of the vulnerable families, with a further 14% referred to CSC by other agencies. A further 122 unborn babies were already known to CSC, as there was a social worker engaged with the family.

Staff we spoke with knew how to identify adults and children at risk of, or suffering, significant harm; and could reiterate safeguarding themes commonly encountered. The majority of midwives we spoke with knew how to make a safeguarding referral.

Staff we spoke with said that known safeguarding issues were identified via the use of red sheets in manual record files and were flagged in electronic records. However, we observed that accessing safeguarding and mental health information on the electronic patient record was not always straightforward. For example, it sometimes involved scrolling through multiple clinical entries to find relevant notes; and potential concerns were not always clearly displayed on summary information pages.

A CQC review of health services for looked after children and safeguarding in Bradford took place in February and March 2019 (published June 2019). It found that maternity service staff at the trust were not consistently sharing information with GPs and communication and information sharing between maternity staff at the trust and the local community health visiting team was ineffective.

In the period July 2018 to July 2019 we saw there had been two serious case reviews (SCRs) involving maternity services. A SCR takes place after a child dies or is seriously injured and abuse or neglect is thought to be involved. They also take place in cases of homicide or criminal activity involving children or adults. A SCR looks at lessons that can help prevent similar incidents from happening in the future.

We saw outcomes from SCRs included improved inter-agency information sharing in relation to sharing of historical safeguarding information; and ensuring that historic social concerns are documented in maternity notes. An audit completed in July 2019 showed 87% of the referrals received from GP's in the review period shared appropriate historical or current health and social information with maternity services. The extent to which appropriate information was shared by maternity service staff with GPs was not detailed.

Hospital maternity staff we spoke with said they had good working relationships with staff from other agencies (such as community midwives and GPs) to safeguard vulnerable women and children, and those at risk of abuse. We Also saw that an action plan had been produced in response to the February and March 2019 CQC review. This highlighted changes made to safeguarding communication practices with GPs and implementing cross-health meeting regarding best practice of information sharing; which were marked as completed.

The June 2019 CQC review also found that midwives at the trust did not consistently attend multiagency meetings or submit reports to child protection conferences. The review concluded that in too many cases, the midwives unique and valuable knowledge of the family and the health of the unborn baby was not being used effectively to inform safety planning and decision making.

We saw an entry on the action plan to ensure that midwives are regularly contributing to the safeguarding process by consistently attending child protection conference and submitted good quality reports to facilitate decision making and robust safety planning. The first action pertained to improving midwife conference attendance. We saw this action (for completion June 2019) had not yet been marked as completed. A small improvement in the submission of written reports was noted in May 2019; however, other work focused on the implementation of the continuity of carer agenda (focusing on vulnerable women case loading) was scheduled to commence March 2020.

A second action, to ensure all 'signs of safety' are completed for child protection conferences was marked as completed. An audit marked to be completed June 2019, and subsequently completed December 2019 showed a small increase in completion of reports for child protection conferences but it was noted that this was not significant. The entry also stated the safeguarding midwifery team was to continue to promote completion in supervision and training.

Senior leaders reported a specialist midwife for PNMH and complex care needs (including learning disabilities) was due to commence employment in late November 2019. Prior to their appointment, staff could seek advice and support from the trust safeguarding team. Staff could also refer women to the weekly perinatal mental health clinic run by the district care trust; however, this was highlighted as more appropriate more acute and higher-risk cases. Please see the assessing and responding to risk section of the report for additional information.

Community midwives were able to refer directly to externally funded community health provision; and had established links with services offered by 'Better Start Bradford'. There was a personalised midwifery case-loading team ('clover') who provided targeted support and care to women in higher-deprivation areas of the locality in the antenatal, perinatal and post-natal period.

There were arrangements in place to safeguard women with, or at risk of, female genital mutilation (FGM). FGM training was delivered as part of safeguarding adults training. The hospital safeguarding team collated FGM statistics to monitor prevalence. We saw that safeguarding leads from the trust had led events to raise safeguarding awareness in June 2019; which included a multi-agency event centre on FGM.

Staff followed a baby abduction policy and understood baby abduction drills. Staff we spoke with said that the last (unannounced) baby abduction drill at the service had been completed in the six months prior to our inspection.

Cleanliness, infection control and hygiene

Overall, staff kept ward equipment visibly clean; however, feedback from women and audit findings suggested cleanliness could be improved in some areas. The service did not monitor or control infection risks in theatres consistently well.

In the 2018 CQC maternity survey, the trust scored 8.2 out of a possible 10 for the cleanliness of rooms and wards; this was similar to the England average.

At our previous inspection of the service, we said that the service should ensure that infection control audits are routinely undertaken in each area. At our most recent inspection, we observed frequent and ongoing infection prevention and control (IPC) audits were taking place and were reported to the monthly divisional IPC committee.

Cleaning records we reviewed on site were up to date and demonstrated that areas were cleaned regularly. Following our inspection, we reviewed monthly audit data that showed cleaning scores were within the range of 97.5% to over 99% across all maternity service areas for the period November 2018 to September 2019.

However, some patients we spoke with on the postnatal ward complained that there had been instances they had found areas (such as bathrooms) in need of cleaning during their stay. We reviewed a sample of recently completed friends and family test (FFT) card responses on the ward and observed that (whilst most indicated they were satisfied with their care) some women had noted issues with ward cleanliness.

We saw that in the period November 2018 to October 2019 'ward hygiene spot checks' had been undertaken in four areas of the maternity service; results ranged from 89% to 98% compliance.

We reviewed Patient-Led Assessments of the Care Environment (PLACE) scores for 2018. The hospital score for cleanliness (97.4%) was slightly worse than the England average (98.5%).

During our inspection we saw staff followed infection control principles, including the use of personal protective equipment (PPE). PPE was available in all areas we visited and provided to staff in the community. Audit data from November 2018 to October 2019 showed dress code and use of PPE compliance was 95.9% on average across the maternity service.

Audit data from November 2018 to October 2019 showed hand hygiene compliance was 98.8% on average across the maternity service.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Dated 'I am clean' stickers were visible on equipment to indicate it was ready for use.

Data showed that from October 2018 to November 2019, the service reported 51 (0.96%) of the 5335 women who birthed at the hospital were readmitted to hospital for infections within one to 30 days following delivery. Over the same period, 33 (0.61%) of 5149 babies born were readmitted to hospital for infections within one to 30 days following delivery.

During our inspection, staff described that the use of the second (emergency) obstetric theatre had been restricted, due to the ventilation system being deemed inadequate. We saw the risk had been added to the maternity risk register in June 2018, and was initially risk scored as 16, and subsequently reduced to 12. The entry described that the ventilation system which supplied maternity theatres did not meet the required standards, resulting in an increased risk of cross-infection during operative procedures. In addition, theatre two should only to be utilised in an emergency, "when theatre one was occupied and there was no other option available. The risk had been added to the corporate risk register in November 2018.

During our inspection, senior staff we spoke with said that capital funding had been obtained to extend and upgrade the two obstetric theatres, the date for completion completed set for approximately two years' time. Following our inspection, senior leaders submitted additional information detailing upgrading plans and a provisional timeline for development.

We reviewed the audit data for 2019, which showed that a retrospective audit was completed for caesarean sections performed during June and July 2019. 49 respondents completed the questionnaire. Of these, 28 cases were performed in theatre one and 21 cases were performed in theatre two. Findings showed the service continued to have a higher wound infection rate at 14% (compared to a national average of 9.6%) and "given the issue with ventilation continued this was not surprising". Audit findings noted that overall improvements in IPC education and practice had contributed to a positive decline in infections rates (2.6%) since the last audit (from 16.6% to 14%).

The obstetric theatres risk assessment (updated November 2019) stated that a Datix (incident report) should be submitted on a weekly basis reporting the number of instances theatre two had been used in that week. Following our inspection, the senior leaders submitted incident data in respect of maternity theatres (the use of theatre two). We saw that from 1 April 2019 to 17 November 2019, 16 incidents had been reported. In one week alone, we saw the theatre was used 10 times. We were unable to calculate the number of women who had procedures performed in theatre two during this timeframe as incident entries were sometimes generic and referred to multiple dates and multiple women, for example, "the use of theatre 2 today and during the week". We also observed that no associated incidents were presented for the months of June and July 2019, whereas audit data (see above) showed at least 21 women had procedures in theatre two during these months.

Following our inspection, senior leaders said that they had been alerted to the fact that incident reporting as per the action plan was not happening but this had now being actioned. Senior leaders

later conducted an audit of theatre use and found theatre two had been used 286 times in (January to December) 2019.

Rooms were available for patients in need of isolation, for example, if women had tested positive for Methicillin-Resistant Staphylococcus Aureus (MRSA). During our inspection, we observed isolation rooms in use and saw appropriate signage was displayed, and enhanced IPC procedures were followed.

There had been no recorded cases of hospital acquired MRSA, Methicillin-sensitive Staphylococcus aureus (MSSA) or Clostridium Difficile within maternity services at the hospital in the last 12 months.

Environment and equipment

The design of the environment and ventilation equipment in theatres did not adhere to national guidance. However, the design, maintenance and use of facilities, premises and equipment in other areas of the maternity service followed national guidance and kept people safe. We identified some omissions in daily checks of emergency adult resuscitation equipment. Staff managed clinical waste well.

The design of the environment did not always follow national guidance. Obstetric theatres one and two were non-compliant with the Health Technical Memorandum (HTM) 03-01: Specialised Ventilation for Healthcare premises. In addition, the design function and space in theatres was not compliant for a standard plenum theatre.

However, we saw that unit security had been improved since our last inspection of the service. There was swipe card access to the unit, and ward reception desks had been relocated immediately adjacent to entrances and exits to improve surveillance monitoring. The post-natal ward also had a ‘lock down’ alarm next to the nurses’ station. Staff we spoke with confirmed that baby abduction drills had been conducted in the six months prior to our inspection.

Staff we spoke with said the service had enough suitable equipment to help them to safely care for women and babies; and we observed equipment was suitably stocked.

At our last inspection of the service, we told the service it must ensure that daily checks of emergency equipment are undertaken in maternity. At our recent inspection, we reviewed four adult resuscitation trolleys and found these were secure, and the equipment reviewed was orderly, in date, and ready for use. However, we noted that daily and weekly checks were not always completed. For example, on the labour ward daily checks had not been completed on six occasions between 26 August and 5 October 2019. We raised our concerns with the trust following our core service inspection and received assurance a new process had been implemented and was being monitored by the leadership team.

The service audited trolley checklist completion. For the period July to September 2019, compliance was (red-amber-green) RAG-rated as amber for the labour ward, postnatal ward, and antenatal clinic. Meaning there was up to six daily checks missing or one weekly check missing during this period, or the trolley had an incorrect oxygen cylinder/kit. The trolley on the antenatal ward was found to be compliant, and rag-rated green.

Following our last inspection of the service, we said the trust should consider revising the checklists for resuscitaires to include the individual checks that need to be made. At our recent inspection, we saw this had been implemented. We inspected five infant resuscitaires across the service and noted only minor omissions in daily and after use checks.

Overall, we saw obstetric emergency trolleys for eclampsia and postpartum haemorrhage (PPH) had been appropriately checked, and were appropriately were stocked, with the equipment was in date

and ready for use. We observed the PPH trolley on the postnatal ward was missing three daily checks for the months August and September 2019.

At our last inspection of the service, we said the service should consider having records of quality control checks for fetal blood gas analysers kept with machines, so staff could be assured checks had been carried out. At our recent inspection, we saw this had been actioned and checks had been completed.

In line with trust Home Birth Guidelines, community midwives had access to the equipment they would use for a home birth. For example, weighing scales, blood pressure cuffs, bariatric scales, sonicaids, and portable suction.

On wards, we observed women could reach call bells and staff responded quickly when called.

We reviewed Patient-Led Assessments of the Care Environment (PLACE) scores for 2018 and saw that the hospital score for condition and maintenance (90.1%) was worse than the England average (94.3%).

Staff disposed of clinical waste safely. We saw processes for segregation of waste including clinical waste; and staff were able to segregate waste at the point of use. Sharps bins were used by staff to dispose of sharp instruments or equipment; and those we observed were secure, not overly full, and stored off the floor.

We found that cleaning chemicals hazardous for health were stored securely.

Assessing and responding to patient risk

Review of intrapartum (and to a lesser extent, postpartum) records showed staff did not always complete and update risk assessments for each woman and act to remove or minimise risks. Not all staff were engaged with and participated in the WHO safer surgery checklist. Internal audit data often showed measures required improved compliance, or the audits had not been completed. Antenatal records we reviewed were of an acceptable standard.

The service had policy and processes in place (for example, 'the management of severely ill pregnant women') to support staff to appropriately assess and respond to risk, and to manage emergencies.

The maternity assessment centre (MAC) opening hours had been extended in November 2018; and the MAC offered a 24-hour, seven days a week, service. Please see the responsive, access and flow section of the report for additional information.

Women who were higher risk or who had experienced previous complications and who were requesting care outside of recommended care pathways, were seen by a consultant obstetrician. Women could also be referred to a new 'birth options' clinic, overseen by the specialist midwife for quality practice, for ongoing support around birth options.

Following our inspection, we requested the number or proportion of outside of criteria women admitted to birth centre or who home-birthed for last 12 months. The trust responded to say that this data was not collected.

There were guidelines for risk assessment at booking, during antenatal care, and during antepartum care. However, we found staff did not always complete and update risk assessments for each woman and act to remove or minimise risks; and this was particularly evident in the intrapartum care records we reviewed.

Risk assessment at antenatal booking took place for all women to determine whether individuals were high or low risk. In records we reviewed, we saw women with risk factors were appropriately

identified and referred to an obstetrician. In addition, we saw antenatal care pathways were clearly documented in most instances.

A nationally recognised tool was used to identify and escalate deteriorating patients. Midwifery staff identified women at high risk by using an early warning assessment tool, known as the Modified Early Obstetric Warning (MEOWs) Score. However, we reviewed intrapartum records and found plotting, calculation and escalation of MEOWS were not appropriately completed in two of the five applicable records reviewed. In addition, we found MEOWS charts were not appropriately completed in two of seven postnatal records we reviewed. The service reported that a maternity service records audit had not been undertaken in the 12 months prior to our inspection, so we were unable assess the extent to which our observations reflected trust MEOWS audit data.

NICE guidance recommends, as a minimum, intrapartum evaluation and documentation every hour, and by a 'fresh pair of eyes' every 2–4 hours (Intrapartum Care: Care of Healthy 'Women and Their Babies During Labour. NICE Clinical Guideline 55). Following our previous inspection of the service, we said that the service should improve the use of 'fresh eyes' reviews of cardiotocography (CTG) for all women during labour. During our recent inspection, we found that of four applicable records, all contained appropriately labelled CTGs. However, we found 'fresh eyes' was only observed as appropriately completed in one instance. In two cases we found 'fresh eyes' was not fully completed, and in one instance the intrapartum record was found to be illegible.

At the service, intrapartum CTG and 'fresh eyes' audits were undertaken by labour ward clinical staff. Between January 2019 to November 2019, data showed compliance over the period averaged 64.5%. Notably, this measure excluded two months (June and August 2019) where no audits were conducted, and included data for July 2019, where only one record was audited. We also saw only three records had been audited for the months of January and May 2019.

We saw completion and documentation of admission summaries, fluid balance charts, and risk assessments (including situation, background, assessment and recommendation (SBAR) tools and pressure sore risk assessments ('Waterlow') were not always completed in the intrapartum records we reviewed.

Some omissions were also noted in postnatal record keeping. We saw that out of seven applicable records, all contained appropriately completed SBAR handover records. However, we observed risk assessments (including 'Waterlow') and fluid balance charts (where applicable) were not always completed.

Senior leaders reported that the service had not conducted a record-keeping (documentation) audit in the 12 months prior to our inspection (please see the safe, records section of the report for information).

Following our previous inspection, we said that the service must ensure all staff are engaged and participated in all steps of the World Health Organisation' (WHO) surgical safety checklist, and that this should be consistently utilised.

At our most recent inspection, we saw new WHO checklists had been implemented in the service since our 2018 inspection. Records we inspected onsite in theatres (recovery) contained appropriately completed checklists. However, we observed the use of the checklist in theatres, and saw not all staff were engaged as directed by the checklist. For example, blood loss and difficult aspiration risks were not discussed during the 'sign in' or 'time out' stages, and there was no verbal confirmation of team members and role at the 'time out' stage. Staff we spoke with said that a briefing safety huddle was not completed prior to the commencing the full theatre list.

We reviewed results pertaining to an audit performed between late-April and mid-May 2019, prompted by a 'retained swab' incident (and after the introduction of the new WHO checklist for maternity cases). 34 patients' case notes were reviewed, and results showed 22 cases (64.7%) were found to be fully compliant. To note, in three cases (8.8%) checklist documentation was found to be missing. Completed counts of accountable items was found in 33 (97.1%) of cases; in one case (2.9%) no count documentation was identified.

Following our inspection, we requested WHO checklist audit data for a 12-month period. The service returned audit data for October 2019, which contained a chart showing audit results from December 2017 to October 2019. Aggregated data for October 2019 (for a two year period) showed compliance was 96.2%.

The service also submitted a chart detailing WHO checklist audit results. Unfortunately, data labels (pertaining to individual monthly measures) were not detailed on the chart. However, we were able to see that in the 12 months prior to inspection (November 2018 to October 2019): compliance was 100% for four of the months (December 2018, April, May and August 2019), 95% to 100% for one month (October 2019), between 90% to 95% for one month (September 2019), between 85% to 90% for four months (November 2018, January, March and July 2019) and marginally under 85% in one month (June 2019). We could not see that data was presented for February 2019.

Data showed that compliance was 100% for November and December 2019, following our inspection.

The service did not undertake observational audits of WHO checklist use.

Public Health England undertook a screening quality assurance visit of antenatal and new born screening programmes at the trust in March 2019. They found a comprehensive screening programme was in place at the service.

There were processes in place in the event of maternal/baby transfer by ambulance, transfer from homebirth to hospital, and transfers postnatally to another unit.

The service had 24-hour access to mental health liaison and specialist mental health support. A specialist midwife for PNMH and complex care needs (including learning disabilities) had commenced employment in November 2019. Prior to this, women with acute or enduring mental health conditions could be referred to an externally provided weekly PNMH clinic, run by an NHS community trust. Women with mild-moderate mental health problems could be referred to community adult mental health services or directly to the 'my well-being' service.

A 24-hour psychiatric liaison and first response team were available at the hospital, who could be contacted to arrange psychosocial assessments and risk assessments for women thought to be at risk of self-harm or suicide. Women with a history of, or current severe, mental health problems could also be referred to the Specialist Mother and Baby Mental Health Service (SMABS). In addition to formal referrals, a SMABS advice line was in operation four mornings a week.

Staff shared key information to keep women safe when handing over their care to others. Postnatal records we reviewed all showed staff used SBAR to facilitate structured and appropriate communication between individuals.

Shift changes and handovers included all necessary key information to keep women and babies safe. We observed a staff handover between the labour ward coordinators, and a handover with the wider maternity team (led by the labour ward coordinator coming onto shift). The team handover attendance included midwives, support assistants, medical and theatre staff. We observed staff suitability identified and discussed patients clinical, social, and psychological circumstances and needs, and plans for ongoing care and (where applicable) discharge.

Midwifery and nurse staffing

Managers accurately calculated and reviewed the number and grade of midwives needed for each shift, in accordance with national guidance. However, midwifery staffing challenges were evident across hospital maternity services, and levels of one-to-one care in established labour were poor. Caseloads among community midwives were within national guidelines and were modified to account for the complexity of cases. Managers gave bank and agency staff a full induction.

The service had experienced significant midwifery staffing challenges; and this was recognised by leaders, managers and staff we spoke with. We saw the "risk that minimal staffing levels within all areas of the maternity services will not be achieved due to long- and short-term sickness levels" had been added to the maternity risk register in May 2019; and at the time of viewing (November 2019) was risk-rated 12. It was acknowledged that this could impact on patient safety, the provision of one-to-one care to labouring women, possible closures of beds and services, diversion of patients to other trusts, and maternity unit reputation.

Data from November 2018 to October 2019 showed an average of 70.1% of women (on the labour and in the birth centre; combined) received one-to-one care in established labour over the period. The proportion of women who received one-to-one care in labour varied from 57.2% to 82.5% over the period. Over the same period, data showed the average proportion of women on the labour ward who received one-to-one care in labour was 70.7%, and for the birth centre this figure was 68.5%. We observed that despite some improvements in the first half of 2019, there had been a period of decline from July 2019. For example, the average proportion of women who received one-to-one care in labour at the hospital from August to October 2019 was 61.7%.

We saw a maternity workforce update letter had been issued to maternity service staff in September 2019. This recognised that the creation of new service areas (the induction of labour suite) and the expansion of others (maternity assessment centre) had improved patient care but had negatively impacted on staff. In addition, maternity leave, and sickness absence were identified as contributing factors. The then vacancy position (described as due to resignations, retirements, and promotion of staff) was noted as 15 WTE midwives.

Following our inspection, senior leaders completed a risk assessment on the provision of one to one care in labour, which was to be kept under review. They described that from January 2020, one to one care in labour was to be a performance indicator on the trust workforce committee and quality committee dashboard.

Managers accurately calculated and reviewed the number and grade of midwives needed for each shift, in accordance with national guidance. The service utilised a daily 'hot desk' midwife; 'hot desk' midwives were band seven midwives who were rostered to monitor and manage staffing within the service (and be a central point of contact) for a given day. They could, for example, assess acuity and reallocate staff to work on different wards, including the labour ward.

At our previous inspection of the service we said that the service should ensure that labour ward coordinators are always supernumerary to supervise staff and provide support. Coordinator supernumerary status was set out in the service policy, 'staffing – labour ward (duties and requirements)' (April 2018). At our recent inspection, we found coordinator supernumerary data (which showed, where provided, coordinators maintained a non-case holding capacity) did not reflect what some staff told us. However, we recognise it was in the remit of labour ward coordinators to relieve staff for breaks, review fresh eyes CTGs, perform difficult cannulation, and the like; and this might have been misconstrued.

At our previous inspection of the service we said that the service should consider strengthening the incident reporting of incidents related to staffing and ensure all opportunities for learning from incidents are taken. Following our recent inspection of the service, we requested NICE 'reg flag' staffing incidents for a 12-month period. However, this was not provided (please refer to the incidents section of the report for more information).

During our inspection, we observed the number of midwives did not always match planned numbers on wards we visited. This was observed throughout most of the service but was particularly evident on the labour ward. We found this was not isolated to the times of our inspection. We reviewed the electronic staffing system, and saw that across maternity services at the hospital, the service was down four midwives on early, late and night shifts against planned numbers on the day selected.

Data supplied by the hospital following our inspection showed that the labour ward had closed 13 times from 05 July to 01 November 2019 (over a period of approximately four months) due to staffing and acuity. Two additional unit closure were also attempted; however, it was noted that neighbouring NHS trusts were unable to take additional women. During this period 23 women were diverted to other NHS trusts to give birth. Over the same period, the birth centre had closed 13 times (not necessarily at the same time as the labour ward). Please see the responsive, access and flow, section of the report for additional information.

Senior staff we spoke with said 22 WTE newly qualified midwives had commenced employment in October 2019; these staff were in their induction period at the time of inspection. We understood that this was similar to the number recruited the previous year; and new recruits were to be distributed across the service, including in the community.

Following our core service inspection, senior leaders had overseen staffing sickness absence and one-to-one care in labour risk assessments, and risk reduction action plans had been developed and implemented. They also reported that the midwifery establishment was to be increased by 5.22 WTE, to enable an additional intra-partum midwife to be on duty per shift; a further 6.33 WTE staff were agreed to cover maternity leave cover.

Trust level

The table below shows a summary of the nursing and midwifery staffing metrics in maternity at trust level compared to the trust's targets, where applicable:

	Maternity annual staffing metrics						
	August 2018 to July 2019						
Staff Group	**Annual average establishment**	**Annual vacancy rate**	**Annual turnover rate**	**Annual sickness rate (target 4.5%)**	**Annual bank hours (% of available hours)**	**Annual agency hours (% of available hours)**	**Annual unfilled hours (% of available hours)**
All Staff	289.9	4%	12%	5.1%	-	-	-
Qualified Nurses	202.1	2%	12%	5.2%	10,842 (3%)	960 (<1%)	9,255 (3%)
Nursing Assistants	56.3	12%	12%	5.3%	9,742 (12%)	104 (<1%)	1,582 (2%)

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing Bank Agency tabs)

Nurse staffing rates within maternity were analysed for the past 12 months and no indications of

significant improvement, deterioration or change were identified in monthly rates for turnover, sickness, bank use or agency use.

Managers limited their use of bank and agency staff (of midwife shifts available from August 2018 to July 2019, less than 4% were filled by bank and agency staff); and they requested agency staff familiar with the service.

We observed that managers made sure all bank and agency staff had a full induction and understood the service.

Midwife to birth ratio

From January 2018 to December 2018 the trust had a ratio of one midwife to every 23.1 births. This was similar to the England average of one midwife to every 24.6 births.
(Source: Electronic Staff Records – EST Data Warehouse)

Data supplied by the trust following our inspection showed that the funded ratio was 1:26; and from October 2018 to September 2019, the trust had a ratio of one midwife to every 26.6 births (range 26.1 to 27).

Data for the 12 months prior to inspection showed the average community caseload within the community teams was 85 women per WTE midwife; which was better than the recommended maximum and reflected the complexity of cases. The current recommended Birth-rate plus ratio, allowing for some changes in allowances and NICE Guidance since 2009, is 96-98 cases per WTE midwife.

There was a personalised midwifery case-loading team ('clover') who provided care to women in the antenatal, perinatal and post-natal period; their caseload size ranged from 25 to 30 women per WTE midwife. Case load sizes reflected the complexity of cases and care provided during labour.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep women and babies safe from avoidable harm and to provide the right care and treatment.

The service had enough medical staff to keep women and babies safe. As of May 2019, there were 39.4 WTE medical staff working in maternity services at the hospital; which included 17 consultants. The service reported a labour ward consultant cover of 98 hours per week, which met national guidance recommendations.

Consultant obstetricians provided resident cover with no other duties on a 'hot week' basis for 45 hours a week (Monday to Friday); and out of hours on call cover for nights and weekends. The on-call consultant was resident in the building until 10pm and was then on call from home. Consultants were available within 30 minutes if required.

In line with Safer Childbirth (2007), there was a minimum of twice daily ward rounds. A consultant undertook a labour ward round four times a day, seven days a week; and completed daily antenatal and postnatal ward rounds for women requiring senior obstetric input.

A duty anaesthetist was immediately available 24 hours a day, seven days a week to cover emergency work on delivery suite, in line with national guidance. There were 10 consultant obstetric anaesthetists. They were job planned to provide elective section cover, and a full day on the labour ward on alternating weeks.

Out of hours there was a trainee anaesthetist supported by a more senior trainee anaesthetist on the main site; who covered junior anaesthetists in acute theatres, critical care and obstetric anaesthesia. They were the first responder to labour ward if the obstetric anaesthesia trainee required assistance, or a second theatre needed to be opened.

There were also two consultants on call out of hours at the hospital, one for acute and one for critical care. The acute consultant also covered obstetrics.

The service had increased theatre staffing provision of an additional registrant on every shift to cover obstetric emergency theatre. Senior leaders said this had helped to avoid midwives being pulled from intrapartum care to scrub for emergency theatre cases.

Trust level

The table below shows a summary of the obstetrics and gynaecology medical staffing metrics in maternity at trust level compared to the trust's targets, where applicable:

	Maternity annual staffing metrics			
	August 2018 to July 2019			
Staff group	**Annual average establishment**	**Annual vacancy rate**	**Annual turnover rate**	**Annual sickness rate**
Target		0.0%	0.0%	4.5%
Medical staff	42.5	-2.0%	0%	1.8%

The negative value indicates that the department had over establishment.
(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, and Sickness tabs)

The service had low vacancy, turnover and sickness rates for medical staff.

Staffing skill mix

The service had a good skill mix of medical staff on each shift and reviewed this regularly.

In May 2019, the proportion of consultant staff reported to be working at the trust was about the same as the England average and the proportion of junior (foundation year 1-2) staff was slightly higher.

Staffing skill mix for the 39.4 whole time equivalent staff working in maternity at Bradford Teaching Hospitals NHS Foundation Trust

	This Trust	England average
Consultant	43%	42%
Middle career^	4%	9%
Registrar group~	46%	44%
Junior*	8%	6%

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2
(Source: NHS Digital Workforce Statistics)

Records

Records were easily available to all staff providing care. However, staff did not always keep clear and detailed records of women's care and treatment; this was particularly evident in the intrapartum records we reviewed. The service had not conducted a comprehensive record-keeping audit in the 12 months prior to our inspection.

All staff could access records easily; however, we found patient notes were not always clear and comprehensive. We reviewed a total of nine sets of records at inspection and found good overall standards of antenatal record keeping. However, we found some omissions in postnatal record keeping, and we found intrapartum record keeping was not of an acceptable standard.

Antenatal records included obstetric/medical, social, and mental health history risk assessments; and we observed good standards of general recording keeping. Care pathways and changes to care pathways were clearly documented in most cases.

The service utilised an electronic patient record; with manual records completed during intrapartum care. We found intrapartum record keeping was not always of an acceptable standard.

We reviewed intrapartum records and found plotting, calculation and escalation of MEWS were not appropriately completed in two of five applicable records reviewed. We saw completion and documentation of admission summaries, 'fresh eyes', fluid balance charts, and risk assessments (including situation, background, assessment and recommendation (SBAR) tools and pressure sore risk assessments ('Waterlow') were sporadically completed. In one instance, most of the intrapartum record reviewed was found to be illegible.

Some omissions were also noted in postnatal record keeping. We saw all records reviewed contained appropriately completed SBAR handover records. However, we observed MEWS charts, risk assessments (including 'Waterlow') and fluid balance charts were not always completed.

Following our inspection, we requested the results of maternity services record keeping audits conducted in the last 12 months. Senior leaders reported that the service had not conducted a record-keeping audit in the 12 months prior to our inspection. However, that records had been audited as part of 'fresh eyes' audits and 'ward accreditation' process audits. In addition, that records were routinely reviewed as part of weekly case note, and incident and complaint reviews.

However, we found 'fresh eyes' audits had been completed intermittently. In addition, when completed, audit compliance results for recording and monitoring of CTG and 'fresh eyes' was low; from January 2019 to November 2019, the average compliance for records audited was 64.7%.

'Ward accreditation' documentation submitted by the service following our inspection was for three audits all undertaken in October 2019; pertaining to the labour ward, birth centre and antenatal ward only. Furthermore, we saw 'ward accreditation' process audits comprised of checking three patient records for relevant sections.

Following our inspection of the maternity service, the service submitted evidence of thematic analysis or learning in relation to record keeping standards resulting weekly case note or incident and complaint reviews; however, we found these provided limited assurance of record keeping compliance monitoring.

We saw an abdominal palpation and vaginal examination audit (comprised of 50 record reviews) had been undertaken in October 2019, following on from a serious incident in the service. Please see the incidents section of the report for additional information.

Records were stored securely. We saw secure storage facilities for paper records at the hospital, and procedures for safe storage of electronic were in line with data protection requirements.

When patients transferred to a new team, there were no delays in staff accessing their records. Except for manual intrapartum records, the service utilised an electronic patient record system; which was available to staff, and other local NHS trusts.

Medicines

Medicines were secure and stored appropriately; and staff followed current national practice to check patients had the correct medicines. However, the service did not always use systems and processes to safely record controlled drugs and monitor compliance.

During our inspection, we saw that controlled drugs and medicines were secure, and stored appropriately.

Following our previous inspection of the service, we said that the service should ensure fridge temperature monitoring was taking place in maternity areas. At our recent inspection, we saw the checking of medicines and daily recording of medicines refrigerator temperatures was taking place; and were within range. In addition, the audit data supplied showed good compliance.

At our previous inspection of the service, we said the trust should ensure that up to date patient group directions (PGDs) are used in maternity. At our recent inspection, we saw that all PGDs reviewed were up to date; however, we observed that some PGDs did not list all relevant staff members able to administer medicines under the PGD.

At inspection, we saw staff followed current national practice to check patients had the correct medicines. We reviewed five electronic prescription charts and found these to be complete; and observed the prescribing doctor's printed signature, bleep number or General Medical Council number were documented.

We saw staff reviewed patient's medicines regularly and provided specific advice to patients and carers about their medicines. Patient records we reviewed showed medicines were prescribed and administered in line with hospital and professional guidance.

However, during our inspection, we observed staff did not always follow correct systems and processes to safely record the use of anaesthesia and controlled drugs.

On the labour ward and in the maternity assessment centre (MAC), controlled drugs checks were required daily. On the labour ward we observed some minor omissions in controlled drugs record keeping checks, which included one missing daily check, and limited entry dates for epidural prescriptions and destruction. We found several missing controlled drug register checks in the MAC controlled drugs register, which included absence of checks for a four-day period in November 2019.

We reviewed controlled drugs registers on the antenatal and postnatal wards for up to six months prior to our inspection; where controlled-drugs checks were required on a weekly basis. On the antenatal ward, we saw one week had been missed over this period, and for both the antenatal and postnatal wards we saw that checks were often in excess of seven consecutive days.

We saw the medicines safety officer had overseen a storage and handling of controlled drugs audit (September 2019). Seven wards from the women's and children's unit were audited; however, of

these, only two were audited from maternity services (the antenatal ward, and the postnatal ward – including transitional care); and results were not presented at ward level.

When audited by senior maternity service staff as part of the 'ward accreditation' process in October 2019, expired controlled drugs were identified on the antenatal ward; which scored 87% for compliance, overall. The labour ward and the birth centre were both found to be 100% compliant for medicines management.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. We saw medicine alerts and drugs safety updates were discussion at governance committees and meetings. For example, there was a bi-monthly maternity services multidisciplinary forum. In the May 2019 meeting minutes, we saw there had been a recent drug administration error in the service, and a rapid response out to all staff and drug administration audit ongoing.

We observed a trust medicines management newsletter was produced and displayed in staff areas we visited. This contained details of medicines management priority areas of focus; for example, we saw a recent newsletter outlined correct prescribing and dosing (including, discontinued, missed, and rescheduled dosing) procedures.

Incidents

Staff reported serious incidents in line with trust policy; however, they did not always report other incidents and near misses. When things went wrong, staff apologised and gave women honest information and suitable support. Lessons learned from incidents were shared with staff.

The trust had a policy for reporting incidents, near misses and adverse events, which staff accessed through the intranet. This provided staff with information about reporting, escalating and investigating incidents.

Never events

From August 2018 to August 2019, the trust did not report any never events for maternity. The service reported that two never events had occurred in the service in April and June 2018.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

Staff reported serious incidents clearly and in line with trust policy.

Trust level

In accordance with the Serious Incident Framework 2015, the trust reported two serious incidents (SIs) in maternity which met the reporting criteria set by NHS England from August 2018 to August 2019. Following our inspection, senior leaders reported no SIs had been declared in maternity since August 2019 to the date of our inspection.

A breakdown of the incident types reported is in the table below:

Incident type	Number of incidents	Percentage of total

Maternity/obstetric incident meeting SI criteria: mother and baby (this include foetus, neonate and infant)	1	50.0%
Surgical/invasive procedure incident meeting SI criteria	1	50.0%
Total	**2**	**100.0%**

(Source: Strategic Executive Information System (STEIS)

Prior to our inspection, the trust reported a SI ('surgical/invasive procedure', as detailed in the table above) had occurred in the maternity service. This was in relation to the management of wound infection (which was dated to late November 2018). However, upon reviewing the incident summary, it appeared that the incident had occurred in the gynaecology core service.

We requested and reviewed the last three completed serious incident reports that had occurred at the service. Two of these were in relation to never events, and one was in relation to a serious incident (neonatal death).

We reviewed the investigation reports and saw these included chronologies of events, contributing factors, identification of lessons learned and recommendations to prevent reoccurrence of the incidents.

We saw inadequate counting process in maternity services were seen to be contributing factors in relation to the never events

The third, and most recently completed serious incident report was in relation to a neonatal death, which occurred in the latter half of 2018. We saw that an independent clinical review was sought as part of the investigation. Outcomes from learning included a review of current procedures regarding inductions, reminding staff about the importance of documentation, auscultation of fetal heart, and positioning of fetus, and updating the induction of labour use of oxytocin guideline. An abdominal palpation and vaginal examination audit (comprised of 50 record reviews) was undertaken in October 2019; and an action plan and exception report were produced.

However, we observed that a concern raised by the external reviewer, regarding no use of the emergency buzzer, was not reflected in investigation conclusions and recommendations.

We reviewed an investigation into a maternal death (27 days postnatal), that had occurred in 2018. The investigation centred on care received in the emergency department, and it was concluded that there were no omissions in maternity care which could have prevented the outcome.

We saw evidence of staff involved assisting with investigation and providing statements in incident reports we reviewed. For example, we saw that staff who were involved in a never event were invited to attend a round table discussion, to discuss the incident, and explore contributory factors and recommendations.

The service reported that seven incidents which met Health Safety Investigation Branch (HSIB) reporting criteria had occurred at the location since 3 December 2018; six of which were being investigated and reported on (parental consent to investigate was withheld in one case).

We reviewed morbidity and mortality meeting minutes for the last three meetings prior to our inspection. We saw these were multidisciplinary and attended by obstetricians, paediatricians, maternity and neonatal staff. We saw stillbirths and neonatal deaths were discussed on a case-by-case basis, and a summary of medical history, cause of death, and (where relevant) immediate learning points were documented.

The service had adopted the use if the perinatal mortality review tool (PMRT). The PMRT is a national tool developed by MBRRACE-UK to support the standardised investigation of stillbirths and neonatal deaths. Morbidity and mortality meeting minutes indicated the status of the PMRT for

individual cases; that is, whether the PMRT was ready to complete; and we saw learning points documented for individual cases, where these were identified.

The service reported that, at the time of inspection, compliance with standard one (PMRT commenced within 4 months of date of death) and with standard two (parents informed with opportunity for input) both achieved over 95%. Compliance with standard three (multidisciplinary team review and draft report within four months of death) was consistently above the 50% target.

Investigation and root cause analysis (RCA) reports we reviewed showed patients and their families were invited to be involved in serious incident and never event investigations. There was a designated section in which to document what involvement and support had been provided to the patient and their relatives, and who received a final copy of the report for comment.

Managers debriefed and supported staff after any serious incident. Investigation and root cause analysis (RCA) reports were reviewed showed a designated section in which to describe involvement and support provided for staff involved. These included immediate staff debriefs, offers of support from their manager and colleagues, as well as more formalised offers of the support from the trust workplace health and wellbeing centre, if needed.

The hospital had an electronic reporting system in place, staff we spoke with said they were encouraged to report incidents and were aware of the process to do so.

We reviewed incident data for the service reported between 4 November 2018 to 4 November 2019 and extracted incidents related to maternity and obstetric services (acute and community). Data showed 1019 incidents were recorded. Of these, 56% (569) were classified as resulting in no harm, 44% (444) were classified as resulting in low harm, and 1% (six) were classified as resulting in moderate harm. No incidents were classified as resulting in severe harm or death.

However, we were not assured that staff consistently reported all incidents. For example, we observed that use of obstetric theatre two was not consistently (or robustly) reported; please see the ‘cleanliness, infection control and hygiene’ section of this report.

Following our inspection, the service provided details of 29 stillbirths / intrauterine deaths (IUDs) that had occurred between 1 November 2018 and 1 November 2019. The numbers incident reported did not correspond to the number of stillbirths / IUDs recorded; please see the effective, patient outcomes section of the report for more information.

In addition, following our previous inspection of the service we said that the service should consider strengthening the incident reporting of incidents related to staffing and ensure all opportunities for learning from incidents are taken. Following our recent inspection of the service, we requested NICE ‘reg flag’ staffing data for a 12-month period. One-to one care in labour data was returned. However, we found other NICE reg flag staffing data (which was collated from incident reports) had not been consistently collected and problems were identified with the data (see the effective, evidence-based care and treatment section of the report for additional information) . In addition, inherent issues with an associated data collection pilot on the labour ward (March to May 2019) was reported. Senior leaders responded to say that a new system had been introduced (and rolled out in November 2019); however, we were not assured staffing incidents had been consistently reported by staff in the intervening period. Following our inspection, senior leaders confirmed that there had been no interim measures to ensure these were consistently reported.

Staff met to discuss the feedback and look at improvements to patient care. There were monthly clinical incident panels. During our inspection, we also saw posters in staff areas that detailed incident case review meetings were held on a weekly basis and staff were invited to attend.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff reported feedback was received via team meetings and at handovers. We saw a 'rapid response' bulletin had been issued to staff following never events in the service. The service also used other internal communication methods to inform staff of learning and changes to practice; for example, the labour ward produced a newsletter 'labour ward latest'. A senior member of staff also showed us a closed social media group, on which incident summaries and lessons learned had been disseminated to staff.

There was evidence that changes had been made as a result of feedback. We observed recommendations and actions resulting from investigation and root cause analysis of never events had been implemented. Following the most recent serious incident, we saw that immediate actions included issuing rapid response alerts around the importance of completing specific documentation, which was also included in the service newsletter. A follow-up audit had also been completed.

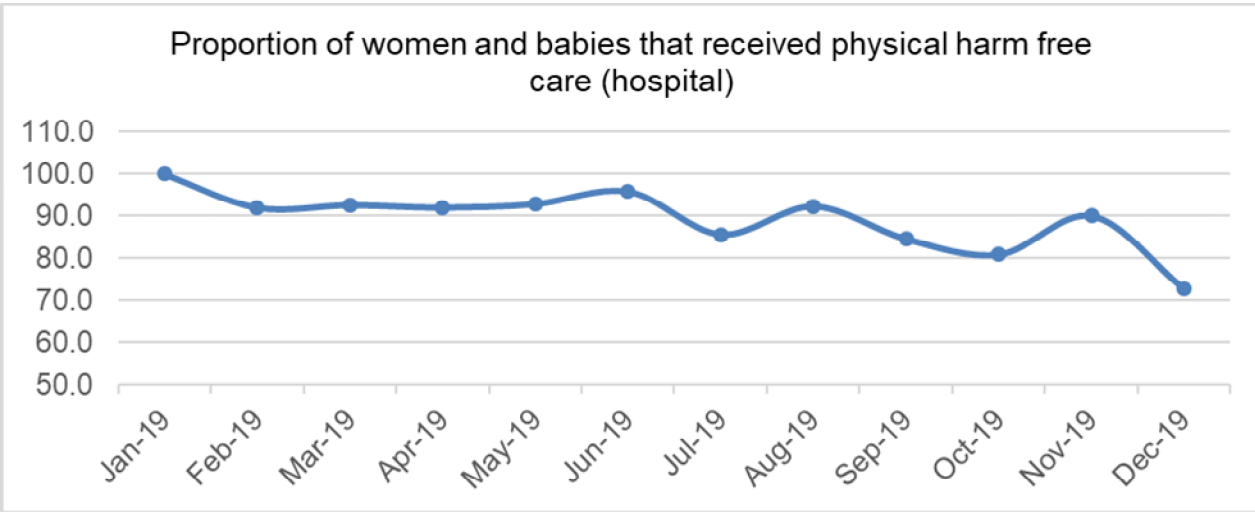
Staff understood the duty of candour. Staff we spoke with said they were open and transparent and gave patients and families a full explanation if and when things went wrong. In RCA investigations we reviewed, we observed that duty of candour was documented as completed. Duty of candour is a regulatory duty that relates to openness and transparency, it requires providers of health and social care services to notify patients (or other relevant persons) of certain incidents and events.

Safety thermometer

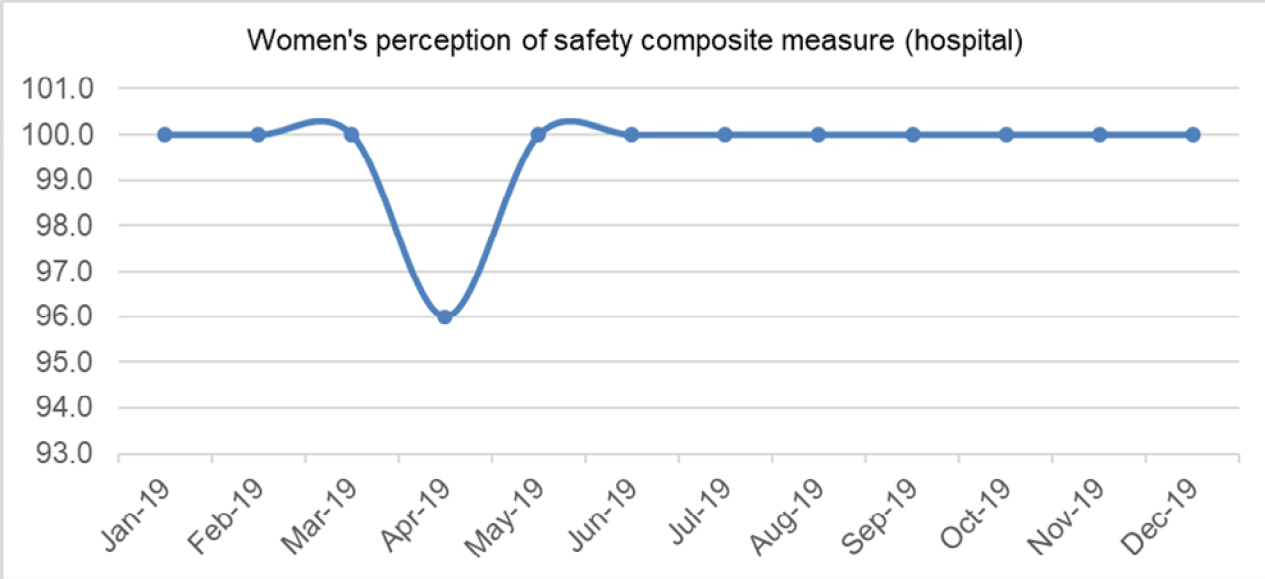
Staff collected and monitored safety thermometer information.

The NHS safety thermometer is a national improvement tool for local measuring, monitoring and analysis of harm and to assist in working to achieve harm free care. The service submitted data to the maternity safety thermometer. Data collection took place one day each month.

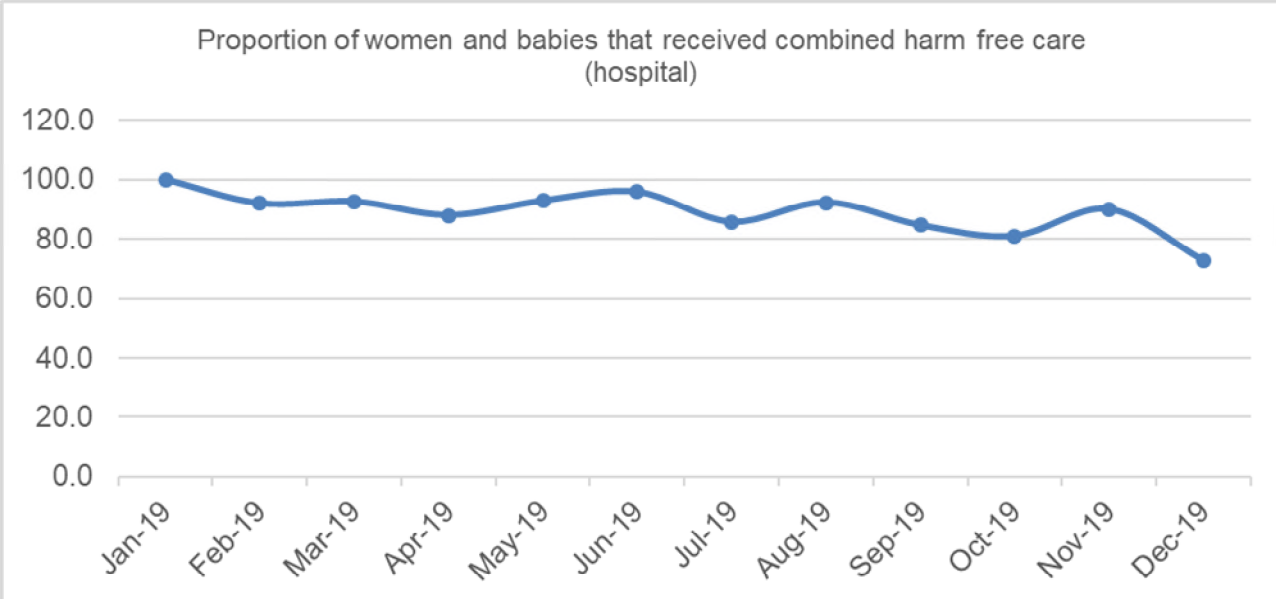
The safety thermometer data showed the service did not achieve over 95% harm free care for the last 12 months. The average proportion of women and babies that received physical harm free care from January to December 2019 at the hospital was 89.3% on average over the period.



On average, 99.7% of women reported they perceived the care delivered to be safe over the 12-month period.



The average proportion of women and babies combined that reported they received harm free care from January to December 2019 was 89%.



Is the service effective?

Evidence-based care and treatment

The service did not always provide care and treatment based on national guidance and evidence-based practice; we saw some guidance was not fully implemented or was contradictory. In addition, some key audits had not been appropriately monitored or completed.

There were up-to-date policies to plan and deliver high quality care according to best practice and national guidance. For example, we found enhanced recovery pathways were in place for those undergoing an elective caesarean section. There was an up to date policy for the management of sepsis and a new maternal assessment pathway for sepsis (MAPS) had been implemented at the service in April 2019. Sepsis training was included in PROMPT training.

As of June 2019, we saw that 96.8% of maternity policies and guidelines were approved and in date. Senior leaders reported that the remaining 3.2% were either under review by the author or going

through the ratification process. Local policies, procedures and clinical guidance were accessible on the trust internet site, which staff found easy to navigate.

In some staff areas we visited, we saw notice boards displaying the 'policy of the week'. These were updated policies (for example, for magnesium sulphate treatment) and we saw staff had to sign these to show they had read and understood them.

We saw the maternity communication team produced a quarterly newsletter, which was circulated to all maternity staff; and this included information about best practice updates.

However, we observed that some key guidance was not fully implemented or was contradictory.

For example, we saw that women did not always receive one-to-one care in established labour (see the safe, midwifery staffing section of the report) and CTGs were not always reviewed by 'fresh eyes' every hour (see the safe, assessing and responding to risk section of the report), as directed by national guidance.

The service did not use customised growth charts, which consider the gestation related optimal weight for each baby, by adjusting for characteristics such as maternal height, weight, parity and ethnic origin. The charts also attempt to predict the growth potential by excluding pathological factors, such as smoking and diabetes. The service did, however, monitor fetal growth from 24 weeks by measuring and recording the symphysis fundal height (SFH) using a standardised growth chart, in line with current NICE Guideline (CG62).

However, we observed that this (at least until comparatively recently) was not always possible. We saw an incident had occurred at the service in Spring 2019, concerning possible missed growth restriction at the end of pregnancy; the baby was born stillborn. Summary details described an ultrasound scan had not been requested, although this was indicated. In addition, no SFH was performed at admission prior to the induction of labour. It was noted that the fundal height chart used by the service only plotted measurements up to 40 weeks gestation, and this might have contributed to the missed growth restriction. During our inspection, senior leaders confirmed that extending the plotting/recording ability of software to 42 weeks gestation had been completed

At our last inspection of the service, we said that the trust should ensure clinical guidance for staff is clear and not contradictory, particularly with regards to fetal growth monitoring.

At our recent inspection, we saw guideline advice regarding fetal growth monitoring continued to be contradictory. Reference continued to be made to Royal College of Obstetricians and Gynaecologists (RCOG) guidelines, which recommend that SFH should be plotted on a customised growth chart. In addition, the appended 'Midwifery best practice competency document' referred midwives to a Perinatal Institute (2009) Detection of Fetal Growth Restriction document; which also advocated the use of customised charts.

Senior leaders reported they were currently in the process of reviewing the Saving Babies' Lives Version Two: A care bundle for reducing perinatal mortality (NHS England, 2019); with the intention of full implementation by the end of March 2020. The updated bundle does not mandate the use of customised growth charts. However, it does state the preferred pathway should be agreed with local commissioners (CCG) following advice from the provider's clinical network as to whether the variation is acceptable.

Staff we spoke with in antenatal clinics and in the community said they emphasised the importance of fetal movements to women as a method of fetal surveillance. We saw baby movement patient information leaflets and 'wellbeing wallets' were available at the location; produced locally and by national charities. We also saw a case study of barriers to women presenting with fetal movement concerns had been completed in late 2018. The service reported an increase in the number of

women attending the maternity assessment centre (MAC) with reduced fetal movements since implementing these measures and extending MAC opening hours.

We were not assured that managers always checked to make sure staff followed guidance, as some key audits had not been completed or appropriately monitored.

The service participated in local and national benchmarking audits. However, we found some key internal audits had not been completed in the 12 months prior to inspection; such as a documentation audit (see the safe, records section of the report). In addition, we saw the monthly 'fresh eyes' audit had not been appropriately completed or monitored in the 12 months prior to inspection (see the safe, assessing and responding to risk section of the report).

The April 2019 to March 2020 maternity audit plan provided following our inspection of the maternity service also indicated that a number of audits were behind schedule or their status was not indicated (for example, the venous thromboembolism (VTE) audit).

We also observed idiosyncrasies in the audit plan itself, signifying delays or lack of monitoring in other audit areas. For example, the 'co monitoring in pregnancy' audit was in the 2019-20 plan, and marked as completed, but the schedule showed this had commenced September 2018 and had been completed in February 2019. Likewise, the '20-week scan (re audit)' featured in the 2019-20 plan and was marked as having commenced in March 2018 and completed in April 2019; with no indication of the 2019 to 2020 audit status given. Likewise, the 'NT [nuchal translucency] image review' (monthly, rolling) audit was marked as completed April 2019, with no updated details entered.

At handover meetings, staff routinely referred to the psychological and emotional needs of women, their relatives and carers. We observed a staff handover between the labour ward coordinators, and with the wider maternity team (led by the labour ward coordinator coming onto shift). We saw staff identified and discussed patients clinical, social, and psychological circumstances and needs. Staff used situation, background, assessment, recommendation (SBAR) to facilitate structured handover of care.

Nutrition and hydration

Staff gave women enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for women's religious, cultural and other needs.

Staff made sure women had enough to eat and drink, including those with specialist nutrition and hydration needs. Women we spoke with said they had their nutrition and hydration needs met. We saw the service made adjustments for women's religious, cultural and other needs.

We reviewed Patient-Led Assessments of the Care Environment (PLACE) scores for 2018 and saw that the hospital score for organisational food (89.4%) was similar to the England average (90%). Ward food scores for the hospital (84.4%) were lower than the England average (90.5%).

However, we found staff did not always fully and accurately complete patients' fluid charts, where needed; see the safe, assessing and responding to risk and records section of the report for additional information.

Specialist support was available for women who needed it. There was a specialist infant feeding coordinator at the trust. They led on the implementation and training associated with the United Nations Children's Fund (UNICEF) Baby Friendly Initiative (BFI) standards. The UNICEF initiative is a worldwide programme that encourages maternity hospitals to support women to breastfeed. The

service was first fully accredited in 2004, and due for reassessment in March 2018; however, publicly available (UNICEF BFI) information stated the assessment was still pending.

The maternity services report presented to the July 2019 quality committee highlighted the service needed to improve breastfeeding initiation rates and work towards BFI reaccreditation. We saw the service had introduced breastfeeding drop in sessions for women with feeding difficulties and peer support.

Regional maternity dashboard data showed that from June 2018 to July 2019, breastfeeding initiation rates at the trust were 69.4% on average. This was similar to the Yorkshire and Humber average for the period (69.8%).

Pain relief

Staff assessed and monitored women regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Information was available about the pain relief options available to women, these included gas and air (Entonox), pethidine and an epidural. Anaesthetic cover was provided on the delivery suit 24 hours a day and included an epidural service.

A birthing pool was available on the labour ward and in the alongside birth unit, and the service had labour mobility aids (such as birthing balls) available, for women who wished to use them.

Women received pain relief soon after requesting it. Women we spoke with said they were able to access pain relief in a timely way, analgesia was offered regularly, and their pain was well managed, overall.

In the 12 months prior to our inspection, the trust had undertaken a pilot study to monitor delays in providing the epidural service. Data from March to May 2019 showed 13 occasions where women waited longer than 30 minutes for an epidural. However, it was noted that it was not possible to determine if this was due to midwifery staffing or anaesthetist availability.

Staff assessed women' pain using a recognised tool and gave pain relief in line with individual needs best practice. We observed staff using pain scoring tools to assess patients' levels of pain; and staff recorded this information on the modified early obstetric warning (MEOWs) score record.

Staff prescribed, administered and recorded all pain relief accurately. We reviewed five electronic prescription charts and found these to be complete; and observed the prescribing doctor's printed signature, bleep number or General Medical Council number were documented.

Patient outcomes

The service monitored patient outcomes, and outcomes for women were typically good. However, we found there had not been sufficient oversight of or concerted efforts to improve the stillbirth rate in the 12 months prior to our inspection. In addition, staff did not always use audit findings to make improvements and achieve good outcomes; for example, only one action resulting from the MBRRACE-UK 2018 audit (formulated December 2018) had been completed.

The service participated in national clinical audits; for example, the National Neonatal Audit Programme (NNAP), National Maternity and Perinatal Audit Programme (NMPAP), and Maternal, New-born and Infant Clinical Outcome Review Programme (MBRRACE UK Audit).

Overall, the service performed well in the most recent NNAP audit. However, NMPAP audit data showed the case-mix adjusted proportion of small-for-gestational-age babies (birthweight below 10th centile) who are not delivered before their due date (72.9%), and the proportion of elective deliveries (caesarean or induction) between 37 and 39 weeks with no documented clinical indication for early delivery (44.1%), were higher than expected. The MBRRACE-UK Perinatal Mortality Surveillance Report for births in 2016 showed the stabilised and risk-adjusted perinatal mortality rate was higher than peer group comparators.

At our previous inspection of the service (2018) we identified the trust consistently reported a higher proportion of stillbirths compared to the regional average, over the 2017 period; and a stillbirth care bundle had been implemented to focus on specific areas to try and reduce this figure.

Following our most recent inspection, we saw there had been a marked increase in the total stillbirth rate, the stillbirth at term with low birth weight rate, and total stillbirth rate adjusted for lethal abnormalities in the 12 months prior to our inspection. Furthermore, these were over double regional averages.

We identified that there had not been sufficient oversight of or concerted efforts to improve the still birth rate in the 12 months prior to our inspection, and actions resulting from the MBRRACE-UK 2018 audit had not been implemented.

National Neonatal Audit Programme

The table below summarises Bradford Royal Infirmary's performance in the 2018 National Neonatal Audit Programme's report against measures related to maternity care:

Metrics ***(Audit measures)***	**Hospital performance**	**Comparison to other hospitals**	**Meets national standard?**
Are all mothers who deliver babies from 24 to 34 weeks gestation inclusive given any dose of antenatal steroids? ***(****Antenatal steroids reliably reduce the chance of babies developing respiratory distress syndrome and other complications of prematurity)*	89.1%	Within expected range	✓
Are mothers who deliver babies below 30 weeks gestation given magnesium sulphate in the 24 hours prior to delivery? *(Administering intravenous magnesium to women who are at risk of delivering a preterm baby reduces the chance that the baby will later develop cerebral palsy)*	68.3%	Within expected range	No current standard

(Source: National Neonatal Audit Programme)

National Maternity and Perinatal Audit Programme

The table below summarises Bradford Women's and Newborn Unit's performance at Bradford Royal Infirmary in the 2018 National Maternity and Perinatal Audit Programme's report against measures related to maternity care.

Metrics ***(Audit measures)***	**Hospital performance**	**Comparison to other hospitals**	**Meets national standard?**

Trust-level case ascertainment (*Proportion of eligible cases included in the audit)*	103.9%	N/A	✓
Antenatal measures (*before birth, during or relating to pregnancy)*			
Case-mix adjusted proportion of small-for-gestational-age babies (birthweight below 10th centile) who are not delivered before their due date *(Babies who are small for their age at birth are at increased risk of problems before, during and after birth)*	72.9%	Higher than expected	No current standard
Intra-partum measures (*during labour and birth)*			
Case-mix adjusted proportion of elective deliveries (caesarean or induction) between 37 and 39 weeks with no documented clinical indication for early delivery (*For babies with a planned (or elective) birth, being born before 39 weeks is associated with an increased risk of breathing problems. This can lead to admission to the neonatal unit. There is also an association with long term health and behaviour problems)*	44.1%	Higher than expected	No current standard
Case-mix adjusted overall caesarean section rate for single, term babies (*The overall caesarean section rate is adjusted to take into account differences which may be related to the profile of women delivering at the hospital)*	21.4%	Lower than expected	No current standard
Case-mix adjusted proportion of single, term infants with a 5-minute Apgar score of less than 7 (*The Apgar score is used to summarise the condition of a newborn baby; it is not always a direct consequence of care given to the mother during pregnancy and birth, however a 5 minute Apgar score of less than 7 has been associated with an increased risk of problems for the baby)*	1.0%	Within expected range	No current standard
Case-mix adjusted proportion of vaginal births with a 3rd or 4th degree perineal tear (*Third or fourth degree tears are a major complication of vaginal birth. Only tears that are recognised are counted therefore a low rate may represent under-recognition as well as possible good practice)*	3.5%	Within expected range	No current standard
Case-mix adjusted proportion of women with severe post-partum haemorrhage of greater than or equal to 1500 ml (*Haemorrhage after birth is a major source of ill health after childbirth. Blood loss may be estimated by visual recognition or by weighing lost blood. High rates may be due to more accurate estimation and low rates due to under recognition)*	2.2%	Within expected range	No current standard

Post-partum measures (*following birth)*			
Proportion of live born babies who received breast milk for the first feed and at discharge from the maternity unit (*Breastfeeding is associated with significant benefits for mothers and babies. Higher values represent better performance)*	N/A	N/A	No current standard

(Source: National Maternity and Perinatal Audit Programme)

Maternity active outlier alerts

As of September 2019, the trust had one active maternity outlier. This was a CQC generated alert for puerperal sepsis and other specified puerperal infections. This alert was passed to inspectors in December 2018 in order to monitor the progress of the trust's action plans.

Bradford Royal Infirmary maternity unit was identified by CQC as being a national outlier for the number of diagnoses of puerperal sepsis cases reported between July and October 2017; the trust received notification of this in July 2018.

Following the alert, three senior obstetricians and the trust the clinical effectiveness team undertook an audit of cases (28) identified during this period. The obstetricians identified cases where 'sepsis' had been coded and observed in many cases that patients had a diagnosis of infection only. They reported that 'true sepsis' was observed in eight (28.6%) of the 28 cases only; and other patients had a range of different infections, which demonstrated that sepsis was being over coded. We saw an action plan had been developed by the service in 2018, containing five actions, which were shown as completed in full by March 2019.

Initial findings prompted actions including updating the sepsis guideline, re-launching the maternal assessment pathway for sepsis, and improving documentation. The service reported these messages were reinforced during PROMPT teaching days for all staff. A wider audit (of 71 cases) was undertaken by clinical coders, which also concluded that sepsis had been over-coded in the records reviewed.

Updated auditing practice involved coders discussing cases they are unsure about with the consultant obstetrician on call, to provide clarification about the patient's diagnosis; and whether to code the case as sepsis or not. A new maternal assessment pathway for sepsis (MAPS) was implemented in the service in April 2019. Data for November 2018 to September 2019 showed there was 24 coded sepsis cases over the period.

(Source: Hospital Evidence Statistics (HES)

MBRRACE-UK Perinatal Mortality Surveillance Report

The table below summarises Bradford Teaching Hospitals NHS Foundation Trust's performance in the 2018 MBRRACE-UK Perinatal Mortality Surveillance Report for births in 2016.

Metrics ***(Audit measures)***	**Trust performance**	**Comparison to other trusts with similar service provision**	**Meets national standard?**
Stabilised and risk-adjusted perinatal mortality rate **(***The death of a baby in the time period*	6.3	Up to 10% higher than the average for the	No current standard

before, during or shortly after birth is a devastating outcome for families. There is evidence that the UK's death rate varies across regions, even after taking into account differences in poverty, ethnicity and the age of the mother.)		comparator group	

(Source: MBRRACE-UK)

Managers did not always use information from the audits to improve care and treatment.

The service provided a document detailing their response to the MBRRACE audit (published 2018). We saw that key points and messages and recommendations had been robustly reviewed and compiled in December 2018. However, we viewed the associated action plan and findings had not been used to make improvements. Of the 12 actions to be implemented, we saw only one was documented as completed. We saw that of the remaining 11 actions, eight were marked with an anticipated completion date of between January and April 2020, no date was entered for one of the actions, and two were yet to be confirmed.

In addition, MBRRACE-UK data for January to December 2017 was published in October 2019. Whilst data from that report is not presented here, this meant that the service was yet to complete or instigate actions from the 2018 report at the time the 2019 report was published.

During our inspection, we requested the trust's most recent National Maternal Perinatal Audit action plan; however, this was not provided. The service responded to say that recent audit results (published October 2019, based on births between 1 April 2016 and 31 March 2017) had not yet been formally reviewed by the divisional governance group. Notably, these results were not provided, and the data presented in this report pertains to that published in the 2018 NMPA audit. A summary of the most recent (2019) audit results was provided by the service. These highlighted better than or similar to national average results for induction of labour rates, third- and fourth-degree tears, and caesarean section rates. However, it was noted that the trust was a significant outlier for small for gestational age babies born at or after 40 weeks. Leaders noted that an action plan pertaining to the 2019 published report was being developed.

The service provided a response to a benchmarking audit (compiled by the local maternity system (LMS) and dated to October 2019) examining the extent to which they had implemented the Saving Babies' Lives Version Two: A care bundle for reducing perinatal mortality (version two, issued March 2019), which needed to be implemented by March 2020. The response showed the service was not currently meeting any of the five elements of the care bundle in their entirety. However, data showed that some elements of the care bundle (for example, reducing preterm births, reducing smoking in pregnancy, and increasing awareness of reduced fetal movements) were close to being achieved; with one to two standards within each element currently not being met. Elements centred on the identification and surveillance of pregnancies with fetal growth restriction (of 11 applicable requirements, six were being met) and effective fetal monitoring during labour (of eight applicable requirements, five were being met) showed more work was needed.

We saw the results of the National Neonatal Audit (2018) had been discussed at divisional level, and risk assessed as low; with the trust performing better than average across most metrics. Measures of parental involvement, rates necrotising enterocolitis, and performance of follow up were identified as the main concerns. In addition, we saw that a local action plan had been produced (led neonatal speciality clinicians) to maintain or improve performance. Updates dated to August 2019 showed a range of actions had been implemented, and were completed, or continued to be monitored for embeddedness.

Standardised Caesarean section rates and modes of delivery

From January 2018 to December 2018 the total number of caesarean sections was lower than expected. The standardised caesarean section rates for elective sections was also lower than expected and rates for emergency sections were similar to expected.

Standardised caesarean section rate (January 2018 to December 2018)					
Type of caesarean	England	Bradford Teaching Hospitals NHS Foundation Trust			
	Caesarean rate	Caesareans (n)	Caesarean rate	Standardised Ratio	National comparison
Elective caesareans	12.8%	435	8.8%	75.4	Lower than expected
Emergency caesareans	16.5%	675	13.6%	84.0	Similar to expected
Total caesareans	29.3%	1,110	22.4%	80.4	Lower than expected

In relation to other modes of delivery from January 2018 to December 2018 the table below shows the proportions of deliveries recorded by method in comparison to the England average:

Proportions of deliveries by recorded delivery method (January to December 2018)			
Delivery method	Bradford Teaching Hospitals NHS Foundation Trust		England
	Deliveries (n)	Deliveries (%)	Deliveries (%)
Total caesarean sections[1]	1,110	22.4%	29.3%
Instrumental deliveries[2]	420	8.5%	12.3%
Non-interventional deliveries[3]	3,430	69.2%	58.4%
Total deliveries	4,960	100%	100% (n=581,697)

Notes: This table does not include deliveries where delivery method is 'other' or 'unrecorded'.
1Includes elective and emergency caesareans
2Includes forceps and ventouse (vacuum) deliveries
3Includes breech and vaginal (non-assisted) deliveries

Values greater than 7 rounded to the nearest 5 with the delivery rate calculated with the rounded figures.

The table above shows that the trust has a lower percentage of both caesarean sections and instrumental deliveries than the England comparison. As a result, the trust does have a higher percentage of non-interventional deliveries (69.2%) than the England comparison (58.4%).

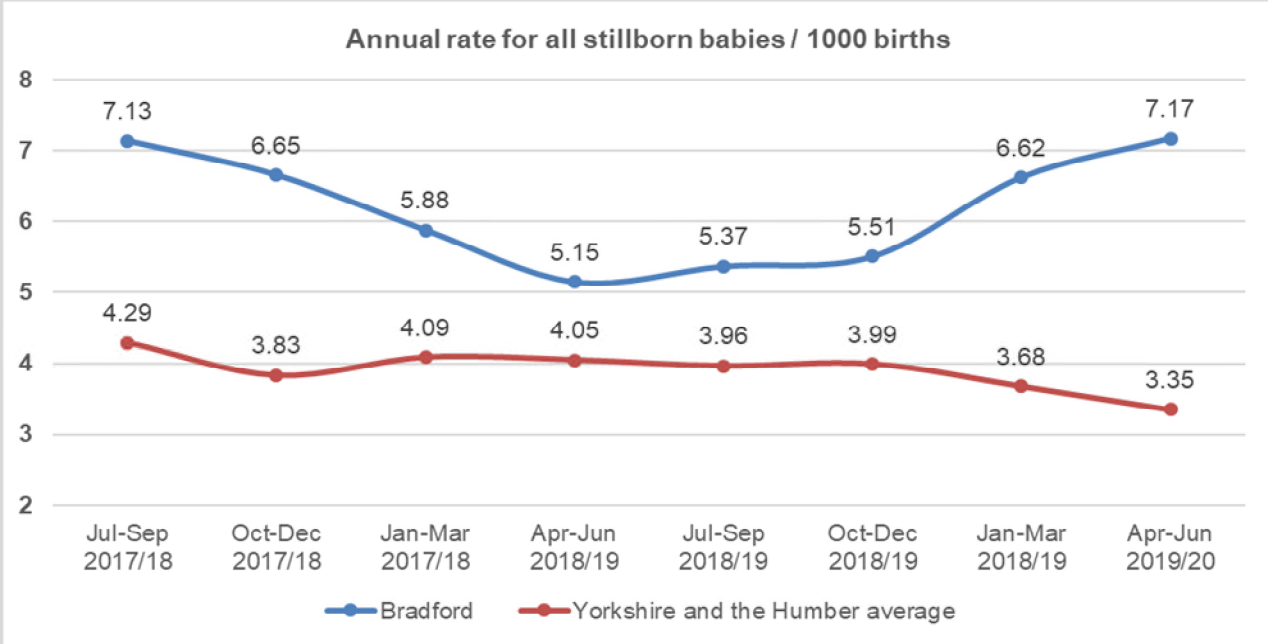
(Source: Hospital Episode Statistics (HES))

To note, the figures detailed above did not included data where delivery method was 'other' or 'unrecorded'. Staffing papers presented to the trust board detailed that there were 5,387 deliveries in the 2018 calendar year.

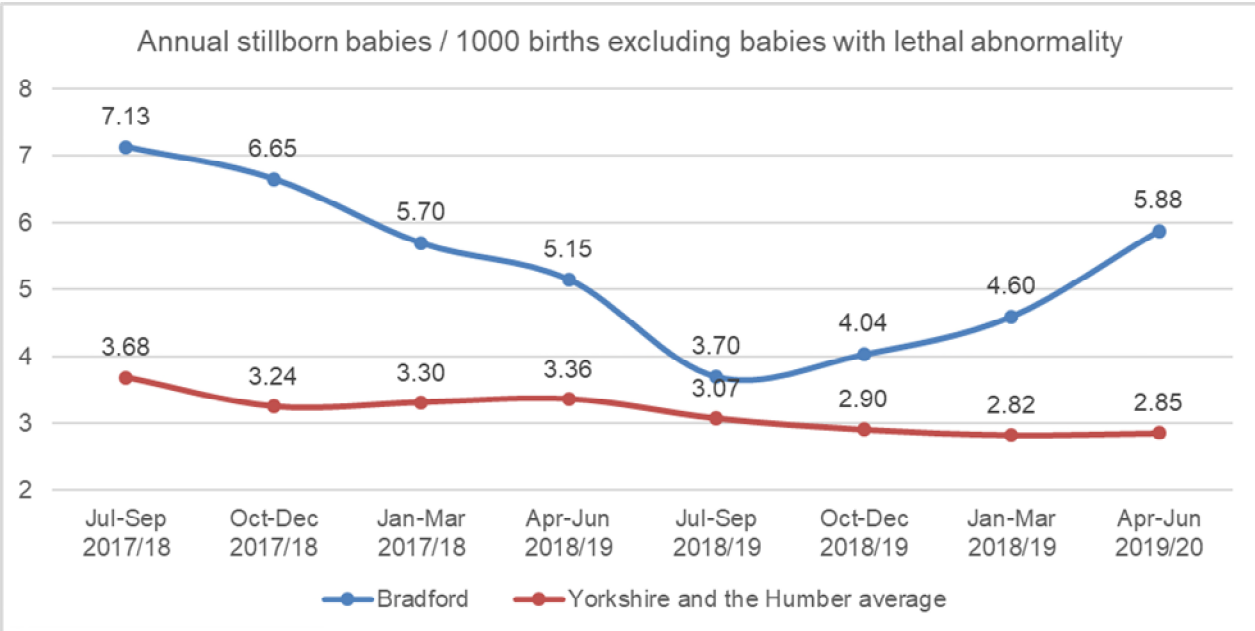
The service monitored patient outcomes using a maternity dashboard and submitted quarterly results to a regional Yorkshire and the Humber maternity dashboard for benchmarking.

We reviewed the most recently available regional maternity dashboard. Maternity dashboard data for the hospital showed that from July 2018 to June 2019 showed 40 stillbirths in total (all were antenatal) were recorded at the trust. This was worse than the Yorkshire and Humber average of 17.3.

As of June 2019, the rolling annual rate for all stillbirth babies per 1000 births at the trust was 7.2. This was worse than the Yorkshire and Humber average of 3.3.



As of June 2019, the rolling annual rate for the total stillbirth rate, adjusted to exclude lethal abnormalities (per 1000 births) at the trust was 5.9. This was worse than the Yorkshire and Humber average of 2.8.



As of June 2019, the rolling annual proportion for the stillbirth at term with low birth weight rate (per 1000 births) was 8.3%. This was worse than the Yorkshire and Humber average of 0%.

There had been no intrapartum stillbirths at the trust over this timeframe.

We could not identify that there had been concerted efforts to monitor and improve the stillbirth rate in the 12 months prior to inspection. For example, we reviewed the last three sets of divisional (women's group) clinical governance meeting minutes and saw the maternity dashboard was documented as being discussed at the September 2019 meeting, but did not feature in July or October 2019 meeting minutes. In addition, we could not identify discussions of trust stillbirth rate data in these meeting minutes.

There was a bi-monthly maternity services multidisciplinary forum (previously the labour ward forum). In the May 2019 meeting minutes, it was documented that: “comparing Yorkshire and Humber data … Bradford currently an outlier for [stillbirths/neonatal deaths]”. These rates were not discussed in the July or September meeting minutes, and we found no evidence of escalation.

We also reviewed maternity services quarterly reports that were submitted to the trust quality committee. The purpose of the report was to provides Quality Committee with an update on the activities of the maternity service, “including key risks, improvements and successes”. However, we could not see that stillbirth rates had been discussed or prioritised as in need of action.

We saw that appended PMRT oversight reports focused on individual case reviews and the proportion of cases in which the PMRT tool had been used (in line with maternity incentive scheme requirements). We observed reports detailed the number of perinatal deaths (for example, that 41 cases were reported from 12 December 2018 to 11 July 2019); however, these did benchmark or contextualise data, to include (for example) perinatal mortality rates (stillbirths and neonatal deaths), or detail any actions considered or subsequently taken to reduce these. Similarly, we observed the same approach in perinatal mortality meeting minutes (please see the safe, incidents section of the report for additional information).

Following our inspection, we sought assurance from senior leaders about oversight of and measures to reduce the stillbirth rate. Leaders later acknowledged that the increase in the 2019 stillbirth rate (46 stillbirths in total from January to December 2019) was above threshold trajectories and required enhanced oversight. We saw a case review and risk assessment had been completed, a still birth action plan had been developed, and relevant national audit action plans had been updated. In addition, a new escalation process (ward to board) had been developed from January 2020.

From October 2018 to June 2019, the average induction of labour rate was 29.0%. This was lower that the Yorkshire and Humber average for the period (31.8%).

From June 2018 to July 2019, the proportion of women who had a normal delivery experienced a third- or fourth-degree tear was 2.0%. This was similar to the Yorkshire and Humber average for the period (1.9%).

The proportion of women who had an assisted delivery and experienced a third- or fourth-degree tear was 7.0%; this was worse than the Yorkshire and Humber average (4.8%).

Over the same timeframe, 2.3% of women experienced a postpartum haemorrhage of greater than 1500mls; this was slightly better than the Yorkshire and Humber average (2.9%).

Competent staff

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

We saw that managers supported staff to develop through regular, constructive clinical supervision of their work. At our last inspection of the service we said that the trust must ensure all staff had undergone an annual appraisal. At our recent inspection of the service, we saw that the appraisal completion rates for staff in the maternity service met trust targets.

Appraisal rates

The breakdown by staff group can be seen in the table below:

Qualified nursing and midwifery, administrative and support staff

Staff group	August 2018 to July 2019				
	Staff who received an appraisal	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Add Prof Scientific and Technic	2	2	100.0%	95%	Yes
Administrative and Clerical	36	36	100.0%	95%	Yes
Estates and Ancillary	2	2	100.0%	95%	Yes
Nursing and Midwifery Registered	192	217	88.5%	95%	No
Additional Clinical Services	44	52	84.6%	95%	No

Following our inspection, the service provided data that showed that as of November 2019, the appraisal compliance rate for qualified nursing, midwifery, administrative and support staff within the maternity service exceeded the 95% trust target.

Medical staff

Staff group	August 2018 to July 2019				
	Staff who received an appraisal	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Medical staff	20	21	95.0%	95%	Yes

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

The service followed the advocating and educating for quality improvement (A-EQUIP) model and framework of midwifery supervision. The Professional Midwifery Advocate (PMA) is a fundamental leadership and advocacy role designed to deploy the A-EQUIP model.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of women. Managers made sure staff received any specialist training for their role. Compliance rates for obstetric emergency, safeguarding, cardiotocography (CTG), bereavement, and perinatal mental health training are reported in the safe, mandatory training section of the report.

The service ran a seven-day new-born and infant physical examinations (NIPE) service. Overall, 9.5% of midwives were NIPE trained. Leaders reported 17 midwives at the service were trained to NIPE and contributed to the rota. In addition, six additional midwives within the service (who didn't routinely contribute to the rota) were NIPE trained.

We saw there were maternity workshops and care compassion and communication workshops, that were combined into two-day courses, and were completed annually by staff. Training topics included clinical risks, blood transfusion, infant feeding, safe administration of medicines, screening, smoking cessation, bereavement care, perinatal mental health, and research updates.

There were a range of specialist midwives available, and 'link' midwives who had specialist interests as part of their roles. These included specialist screening, neonatal examiner, quality midwifery, research, and parent education midwives. A specialist midwife service for teenage pregnancy provided services to Bradford and a neighbouring NHS trust.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. There was a professional development midwife (PDM) in post at the trust, who coordinated training opportunities for all midwifery and support staff and led on the induction of newly qualified midwives.

Managers gave all new staff a full induction tailored to their role before they started work. Senior staff said new starters received a full induction and were supernumerary to staffing establishment figures during their induction period; and this was confirmed by front-line staff.

Support was provided to staff during their preceptorship period (newly qualified midwives) this included support, supervision and review by an identified 'preceptor', protected time for clinical practice focus sessions, and personal reflection and evidence collation.

We saw trainees new to obstetric anaesthesia had at least 20 supernumerary sessions on the labour ward, with direct obstetric consultant anaesthetist supervision prior to going on-call.

Public Health England found a comprehensive screening programme was in place at the service (March 2019); led by competent and qualified staff.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit women.

Staff worked across health care disciplines and with other agencies when required to care for patients. There were established working relationships between maternity and obstetrics staff and colleagues in other disciplines and specialities; for example, neonatal, radiology, dietetics, pathology, neurology and vascular services.

Specialised foetal medicine, cardiology and cardiac care services were provided by another local NHS trust, if required.

Good multi-disciplinary working was evident in clinical areas. Midwifery staff at the hospital and in the community reported good communication, information sharing between departments and cross-site working within teams. Annual emergency obstetric training took place alongside medical staff.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. For women who had certain pre-existing medical conditions, such as diabetes or epilepsy, consultant and specialist midwife led clinics were offered.

The service had introduced multidisciplinary bereavement and palliative care pathways for babies with lethal abnormalities or poor prognoses.

Staff confirmed they could access advice and guidance from specialist nurses/midwives, as well as other allied health professionals.

We saw handovers and ward rounds included multi-disciplinary professionals.

Staff referred women for mental health assessments when they showed signs of mental ill health, depression. Records we reviewed showed mental health risk assessments took place at the booking appointment, and throughout pregnancy. A psychiatric liaison and first response team were available at the trust to respond to and assess women at risk of self-harm or suicide. A specialist midwife for PNMH and complex care needs (including learning disabilities) had commenced employment at the service in November 2019.

Seven-day services

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

Medical staff were available on the maternity unit ward 24 hours a day. Out of regular working hours, there was always a consultant available on call. There was 98 hours per week labour ward consultant cover, which equated to 14 hours a day. Patients were reviewed by consultants depending on the care pathway.

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

The maternity assessment centre provided a 24-hour service; triaging and assessing women from 16 weeks of pregnancy onwards. The antenatal day unit was open five days a week (9am - 5pm).

Maternity services had access to diagnostics and imaging services out of hours.

Anaesthetic cover was provided on the delivery suite 24 hours a day, seven days a week and included an epidural service.

On-call community midwives were available 24 hours a day, seven days a week.

A 24-hour mental health crisis team were available at the hospital seven day a week, and a perinatal mental health midwife was available during working hours.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support on every ward/unit. For example, we saw patient information leaflets and display boards which advised women about leading healthy lifestyles, and safer sleep for babies.

Following our last inspection of the service we said that the trust should consider ensuring that patient information leaflets are up to date. At our recent inspection, we observed that the patient information leaflets available were up to date.

Staff assessed each women's health when admitted and provided support for any individual needs to live a healthier lifestyle. Records we reviewed showed staff had provided information and advice regarding health improvements (such as for high BMI), and had referred women to specialist clinics for pre-existing medical conditions, where indicated.

Across the trust, there were midwives available for support and guidance and with special interests as part of their role. These included midwives who specialised in screening, bereavement, teenage parents, and infant feeding.

However, we saw there was no designated smoking cessation lead midwife in post, due to withdrawal of clinical commissioning group funding. We reviewed smoking cessation referral data for the period June to November 2019 and saw a total of 423 had been offered a referral to smoking cessation services; and of these 285 (67%) had been referred and 138 (33%) had declined referral. Data for an additional 30 women was 'blank'. A paper (staffing review) presented to the board in March 2019 noted that although the service provided an opt out referral to local authority smoking cessation services, this had a low success rate.

Regional maternity dashboard figures for the hospital showed that from July 2018 to June 2019 the average proportion of women smoking at time of delivery was 16.3%. This was higher than the Yorkshire and the Humber regional average (14.3%).

Flu vaccinations were offered to pregnant women during their routine appointments at antenatal clinics, or women could call the service directly to book a vaccination appointment.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported women to make informed decisions about their care and treatment. They knew how to support women who lacked capacity to make their own decisions or were experiencing mental ill health.

Mental Capacity Act and Deprivation of Liberty training completion

Clinical staff completed training on the Mental Capacity Act, achieving the Trust's target. We observed high compliance rates for MCA training among staff in the maternity service. Trust-wide data submitted by the provider showed there were no eligible staff in maternity for the Deprivation of Liberty Safeguards (DOLS) training.

Trust level

The trust set a target of 85% for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training.

A breakdown of compliance for MCA training modules from April 2018 to March 2019 at trust level for qualified nursing and midwifery staff in maternity is shown below:

Training module name	April 2018 to March 2019				
	Eligible staff	Staff trained	Completion rate	Trust target	Met (Yes/No)
Mental Capacity Act Level 1	187	186	99.5%	85%	Yes
Mental Capacity Act Level 2	209	193	92.3%	85%	Yes

A breakdown of compliance for MCA training modules from April 2018 to March 2019 at trust level for medical staff in maternity is shown below:

Training module name	April 2018 to March 2019				
	Eligible staff	Staff trained	Completion rate	Trust target	Met (Yes/No)
Mental Capacity Act Level 2	17	17	100%	85%	Yes
Mental Capacity Act Level 1	18	18	100%	85%	Yes

In maternity, the target was met for all of the MCA training modules for which qualified nursing and midwifery, and medical staff were eligible.
(Source: Routine Provider Information Request (RPIR) – Training tab)

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act; which they said was accessible on the trust intranet.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, and they knew who to contact for advice. Most staff who were asked indicated their first point of contact for guidance and support would be the maternity safeguarding lead, community midwifery colleagues, or the trust safeguarding team.

Staff understood how and when to assess whether a woman had the capacity to make decisions about their care. Staff we spoke with could explain how they might assess a patient's capacity, the steps taken, and the importance of recognising how ill health and other factors could impact on patients' capacity.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff made sure patients consented to treatment based on all the information available. We observed staff interacting with patients and explaining care options and gaining consent at the point of care.

Staff we spoke with could clearly articulated the use of Gillick Competence and Fraser Guidelines for consent of patients under the age of 16 years.

A documentation audit, which typically includes measuring the extent to which consent is compliant in medical records, had not been conducted in the 12 months prior to our inspection.

Is the service caring?

Compassionate care

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

Staff were discreet and responsive when caring for women. Staff took time to interact with women and those close to them in a respectful and considerate way. In wards and departments we visited, we observed staff caring for women and found that they were compassionate and reassuring. We heard staff introducing themselves by name and explaining the care and treatment they were delivering, to the woman or baby.

Women said staff treated them well and with kindness. During our inspection, we spoke with eight patients (sometimes accompanied by their companions), and most of whom described staff care and interactions positively; for example, they said they said despite the unit being "busy", midwives or support assistants usually answered call bells and responded to requests "mostly, quickly". All said that they had been provided with "good" care, and staff were "very good" or "really good".

We saw patient feedback, such as thank you cards were displayed across different areas of the maternity service. In addition, we read a sample of responses from recently submitted family and friend test (FFT) cards. Women described they were "very happy with the care". Staff were described as "amazing", "fabulous", and "incredible".

We saw there had been a recent continuity of carer survey (of different community teams) and women who responded had given positive feedback about the staff involved and the model of care delivered. For example, they said "I loved I saw the same two midwives", and "seeing the same midwife helped [they] … knew me and helped throughout the birth. Very happy".

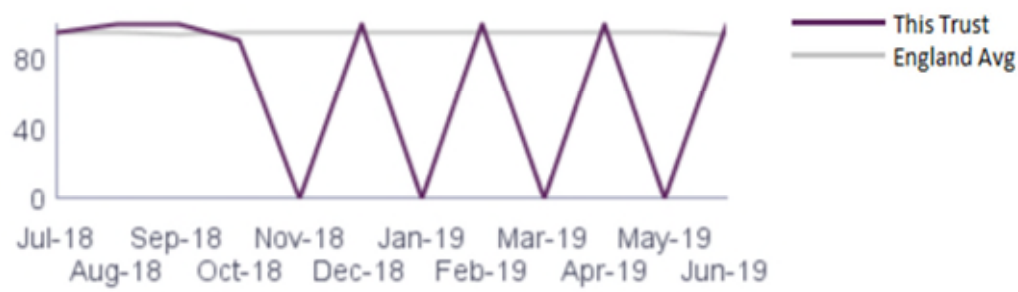
Staff followed policy to keep women's care and treatment confidential. All women we observed were comfortable, looked well cared for and had their privacy and dignity maintained.

Staff understood and respected the individual needs of each woman and showed understanding and a non-judgmental attitude when caring for or discussing women with mental health needs.

Staff understood and respected the personal, cultural, social and religious needs of women and how they may relate to care needs. We observed staff handovers, huddles and interactions included discussion of patients' emotional, cultural, and social needs; alongside their clinical needs and care planning.

Friends and Family test performance

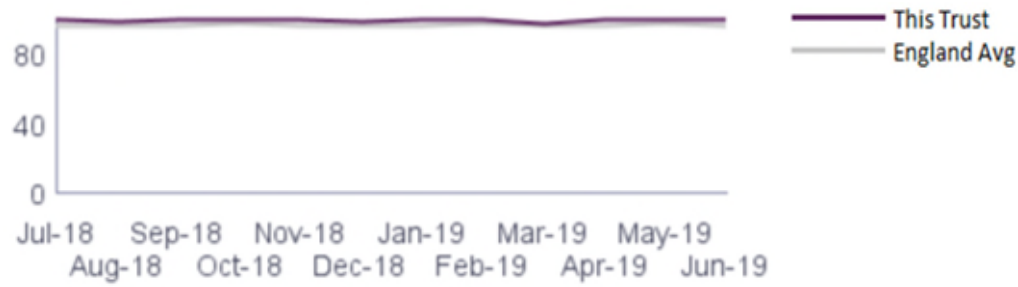
Friends and family test performance (antenatal), Bradford Teaching Hospitals NHS Foundation Trust



From July 2018 to June 2019 the trust's maternity Friends and Family Test (antenatal) performance

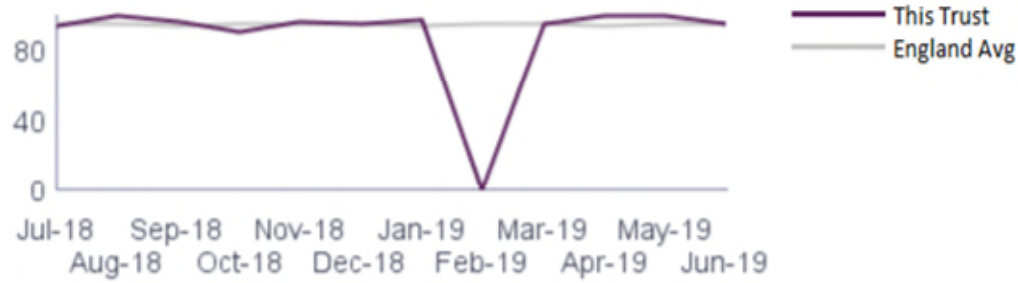
(% recommended) varied when compared to the England average. This variation followed a recurrent trend from October 2018 for every two months where it was above the England average in the first month and then fell subsequently to 0% the following month. This may indicate that there were no data submissions for every second month. However, when the trust did submit data, performance was slightly higher than the England average.

Friends and family test performance (birth), Bradford Teaching Hospitals NHS Foundation Trust



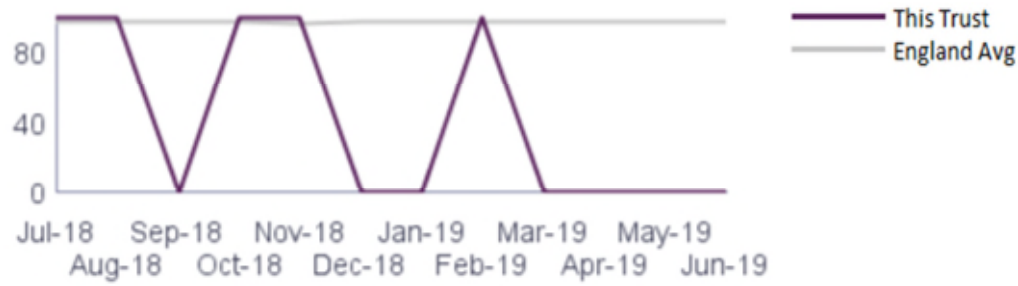
From June 2018 to June 2019 to the trust's maternity Friends and Family Test (birth) performance (% recommended) was slightly better than the England average throughout the time period.

Friends and family test performance (postnatal ward), Bradford Teaching Hospitals NHS Foundation Trust



From July 2018 to June 2019 the trust's maternity Friends and Family Test (postnatal ward) performance (% recommended) was generally similar to the England average excluding February 2019 where the performance dropped to 0%, suggesting a month of no data submission.

Friends and family test performance (postnatal community), Bradford Teaching Hospitals NHS Foundation Trust



From July 2018 to June 2019, the trust's maternity Friends and Family Test (postnatal community) performance (% recommended) was generally similar to the England average excluding those months where the performance dropped to 0%, suggesting months of no data submission.
(Source: Friends and Family Test – NHS England)

CQC Survey of women's experiences of maternity services 2019

The trust performed similar to other trusts for 17 out of 19 questions in the CQC maternity survey 2019 and better than other trust for two metrics; having concerns taken seriously and having the opportunity to ask questions following the birth.

Area	Question	Score (0-10)	RAG
Labour and birth	At the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?	9.3	About the same
	During your labour, were you able to move around and choose the position that made you most comfortable?	7.9	About the same
	Did you have skin to skin contact (baby naked, directly on your chest or tummy) with your baby shortly after the birth?	8.4	About the same
	If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?	9.8	About the same
Staff during labour and birth	Did the staff treating and examining you introduce themselves?	9.2	About the same
	Were you and/or your partner or a companion left alone by midwives or doctors at a time when it worried you?	7.2	About the same
	If you raised a concern during labour and birth, did you feel that it was taken seriously?	9.3	Better
	If attention was needed during labour and birth, did a staff member help you within a reasonable amount of time	9.1	About the same
	Thinking about your care during labour and birth, were you spoken to in a way you could understand?	9.7	About the same
	Thinking about your care during labour and birth, were you involved enough in decisions about your care?	8.8	About the same
	Thinking about your care during labour and birth, were you treated with respect and dignity?	9.5	About the same
	Did you have confidence and trust in the staff caring for you during your labour and birth?	9.2	About the same
	After your baby was born, did you have the opportunity to ask questions about your labour and the birth?	8.0	Better
Care in hospital after the birth	Looking back, was there a delay in being discharged from hospital?	5.2	About the same
	Thinking about response time, if attention was needed after the birth, did a member of staff help within a reasonable amount of time?	8.4	About the same
	Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?	8.5	About the same
	Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?	8.9	About the same
	Thinking about your stay in hospital, was your partner who was involved in your care able to stay with you as much as you wanted?	8.7	About the same
	Thinking about your stay in hospital, how clean was the hospital room or ward you were in?	8.2	About the same

(Source: CQC Survey of Women's Experiences of Maternity Services 2019)

We saw an action plan had been developed following the 2018 national maternity survey (developed in January 2019, and updated November 2019); which contained four overarching actions. These

centred on ensuring women know to contact their GP if experiencing postnatal concerns, ensuring staff introduced themselves at every encounter, improving the advice given to women at the onset of labour, and improving the attention given to women in labour. Each overarching action had a number of actions to be undertaken; several actions were ongoing.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Women we spoke with during our inspection said that although staff were busy, they were available to talk to them and offer emotional support and reassurance.

We saw patient feedback, such as thank you cards were displayed across different areas of the maternity service. In addition, we read a sample of responses from recently submitted family and friend test (FFT) responses. Staff were described as “kind” and “caring”. Some women and their staff gave thanks for “helping us through it all”. One woman described that the “theatre staff were truly amazing – they put us at ease and I’m so thankful …”

In response to a recent continuity of carer (community teams) survey, women were positive about the bespoke care and support provided. One woman described staff were “reassuring in all situations”, and another said they had received “the best of help, care and advice”.

Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them. Perinatal mental health leads from the NHS community trust delivered update and refresher sessions on the annual midwifery update. Training topics covered included caring for women pre-existing mental problems, as well as those at risk of developing mental health problems during the perinatal period.

The service had recently recruited a perinatal mental health (PNMH) midwife, who was due to commence in the role in late November 2019. Prior to this, women with acute or enduring mental health conditions could be referred to an externally provided weekly PNMH clinic, run by an NHS community trust. Women with mild-moderate mental health problems could be referred to community adult mental health services or directly to the ‘my well-being’ service.

Staff supported women who became distressed in an open environment and helped them maintain their privacy and dignity. We saw ‘quiet’, ‘family’ and ‘counselling’ rooms were available across the maternity service for delivering bad news. More recently, provision had been expanded to include an additional bereavement family room, and staff had been involved to raise the funds for this.

There was a dedicated bereavement room (the ‘snowdrop suite’) available for those women and families who needed it on the labour ward. At our last inspection of the service we said the trust should consider making some changes to the suite, so it was less of a clinical environment. At our recent inspection, midwifery staff explained that changes had been considered; and a national bereavement charity (including patient representatives) had been consulted. Consequently, it was felt that the service should maintain a more clinical environment, to avoid women who might have otherwise being able to utilise the room, having to deliver in the main labour ward.

We saw a birth options / debrief clinic had been developed. This was for women who had experienced traumatic births and postnatal experiences, to provide them the opportunity to resolve unanswered questions, help to understand why events may have happened or why decisions were made and discuss plans for a current or future pregnancy and birth. The clinic was led by a specialist midwife for quality midwifery practice, which was a newly created role in the service.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Bereavement training was core mandatory subject on annual 'care and compassion' study days. Additional pregnancy loss training days were also offered to staff. These were multidisciplinary and included midwives, healthcare assistants, and sonographers. They ran for a full day and were offered twice a year. Topics included pregnancy loss from the perspective of different faiths, addressing fears, and making memories. As part of the training, parents who had experienced loss came to share their stories. In the 12 months prior to our inspection, 45 members of staff had attended.

Specialist weekly clinics were held by the bereavement midwife. Follow up arrangements for bereaved mothers were also offered off site, away from the maternity unit.

Since our last inspection, a new pathway had been launched to support women to continue with pregnancy with poor prognosis or lethal abnormalities (the 'butterfly pathway'); and had been developed in conjunction with a specialist hospice. Families on the pathway were offered support, choices and a care plan from a multidisciplinary team comprised of a neonatologist, midwife, geneticists, obstetricians and the perinatal palliative care team based at the partner hospice. This allowed them to make informed choices about their labour and provide the right care for their baby immediately after birth. The service was recently shortlisted for a national award in the "outstanding team care" category.

In addition, the service had worked with the Muslim chaplaincy to provide bereaved families with culturally appropriate keepsakes, in addition to the memory boxes.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. Women we spoke with said they had been involved in decision-making and felt informed about their care.

Information leaflets and advice posters were available on wards we visited. These included leaflets and posters describing medication wards rounds and additional requests, meal times and visiting arrangements. We also saw information displayed about the importance of women feeling able to raise queries or concerns; the messages encouraged women to not worry about asking questions.

In response to a recent continuity of carer (community teams) survey, a woman said of the home birth service that: "I felt like I could ask the midwife anything without feeling like it was a dumb question", and another said they had "all questions and concerns answered informatively".

Staff talked to patients in a way they could understand. We observed staff used clear, concise and easy to understand language when communicating with patients and their companions.

Women and their families could give feedback on the service and their treatment and staff supported them to do this. We saw patient advice and liaison service (PALS) information leaflets, and ways in which service users could make a comment, compliment or complaint were on display in the areas we visited. Women could provide feedback through the FFT survey, on social media channels, and via the maternity voices' partnership group.

Staff supported women to make advanced decisions about their care. Women and their families were offered parent education and preparation for birth workshops and were given 'my pregnancy and birth booklet' at their booking appointment.

We saw a birth options / debrief clinic had been developed. The clinic was available for women who were higher risk or who had experienced previous complications, and who were requesting care outside of recommended care pathways; as an avenue for further discussion and care planning following consultant review. The clinic was led by a specialist midwife for quality midwifery practice, which was a newly created role in the service.

A high proportion of women gave positive feedback about the service in the Friends and Family Test survey. When the trust did submit data, the feedback from the Friends and Family Test was positive for all wards; and performance was similar to or slightly higher than the England average across metrics.

The trust performed similarly to other trusts for all 17 out of 19 questions in the CQC maternity survey (2018). The proportion of women who agreed that they were given appropriate advice and support at the start of labour and were involved enough in decisions about their care during labour and birth, were in line with national averages. The proportion of of women who said their concerns were taken seriously and who had g the opportunity to ask questions following the birth were better than national averages.

Is the service responsive?

Service delivery to meet the needs of local people

There was some evidence that the service worked with others in the wider system and local organisations to plan care. However, service delivery did not always meet the needs of local people.

Maternity services worked with the local commissioners of services, the local authority, other providers, GP's and patients to coordinate care pathways. However, service delivery did not always meet the needs of local people. In addition, capacity and acuity challenges in the service sometimes meant impeding on the wider maternity system to ensure women received the care they needed (please see the access and flow section of the report).

The service was a member of the West Yorkshire and Harrogate local maternity system (LMS). An LMS involves all local commissioners and providers of maternity services as well as service user forums over a wide geographical area.

There was an active maternity voice partnership (MVP); which met frequently and maintained online and social media pages. An MVP is a team of women and their families, commissioners and providers (midwives and doctors) working together to review and develop local maternity care.

Senior leaders and staff were knowledgeable about the socio-demographic profile of women who used the maternity service.

We saw that the service was involved in the 'Better start Bradford' initiative. As part of this, the service had developed a personalised midwifery care project (the clover team). The aim of the project (in line with the continuing care agenda) is to help ensure women can see the same midwife, with longer and more flexible appointments, and enhanced support and information. Facilities and premises were appropriate for the services being delivered. Women had the option to either deliver at home, in the midwifery led unit, or in the labour ward at the hospital.

Community midwives carried out routine antenatal care. Hospital antenatal clinics were available for higher risk women. Midwives could refer expectant mums to the hospital antenatal clinic if they developed any problems.

The service had systems to help care for women in need of additional support or specialist intervention. Specialist antenatal clinics were held, for example, epilepsy clinics. Birth options and debrief clinics were also available. In addition, Midwives were available for support and guidance with special interests as part of their role.

The service had a bereavement room, a water birth room, and high dependency provision.

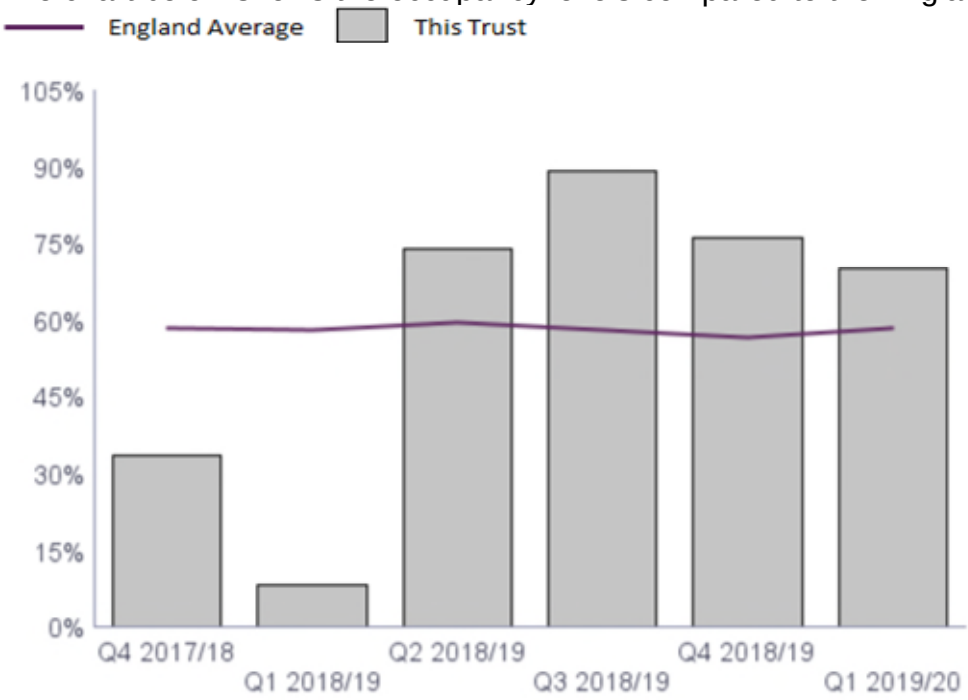
Staff could access emergency mental health support 24 hours a day 7 days a week for women with mental health problems and learning disabilities. Staff could refer women experiencing acute mental health problems to the mental health crisis team; services for support and guidance were also available.

Managers monitored and took action to minimise missed appointments and ensured that patients who did not attend appointments were contacted. There were processes in place to follow up women who did not attend appointments, either in the community or hospital setting.

Bed Occupancy

From January 2018 to June 2019 the bed occupancy levels for maternity were initially much lower than the England average for the first two quarters and then higher for the last four quarters where they were above the England average.

The chart below shows the occupancy levels compared to the England average over the period.



(Source: NHS England)

Regional maternity dashboard data for the hospital showed that from June 2018 to July 2019, 0.8% of all births at the trust were homebirths. This was similar to the Yorkshire and Humber average (1.2%). Following our inspection, senior leaders reported the homebirth rate had also been improved following the launch of the Bradford homebirth team (from less than 1% in 2018, to 3% in October 2019).

Meeting people's individual needs

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

Women booking for maternity care could self-refer, or access maternity care by referral from the GP surgery receptionist, with no GP appointment needed.

Women were offered the choice to deliver at home, in a midwifery-led birthing suite, or in hospital.

The service offered parent education classes run by midwives. Topics included, active pregnancy, labour, birth, active birth, breastfeeding, building a positive relationship with baby, responding to baby, caring for baby and becoming a family.

The service offered specialised clinics for women with complexities such as multiple pregnancies, epilepsy, and diabetes. In addition, debrief clinics and specialist palliative care clinics were offered. As described, there were specialist midwives available for a range of conditions and circumstances.

There was a personalised midwifery case-loading team (clover) who provided targeted support and care to women in higher-deprivation areas of the locality in the antenatal, perinatal and post-natal period.

The transitional care unit allowed mothers to stay with their baby when additional support was needed. For some women, this meant they did not have to be separated from their baby; for example, cases where baby would have otherwise been transferred to the special care baby unit.

A specialist bereavement care midwife was in post and a bereavement room ('snowdrop suite') was available. Quiet, family and counselling rooms were available in different service areas, in the event bad news needed to be delivered.

Staff made sure women living with mental health problems and learning disabilities received the necessary care to meet all their needs. At the time of inspection, perinatal mental health (PNMH) assessment and support provision was shared with a neighboring trust. Leaders reported a specialist midwife for PNMH and complex care needs (including learning disabilities) had commenced employment later in November 2019. A learning disability team was available at the trust for guidance and support.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Information was easily available on the trust intranet on how to access interpreters, both in and out of hours. There were contact numbers for different interpreters, including basic sign language, as well as details on language line.

A CQC review of health services for look after children and safeguarding in Bradford took place in February and March 2019 (published June 2019). It found that women who attended the maternity department who did not speak English benefitted from the services' use of recognised interpreters. In records reviewed, the use of interpreters (when required) was shown to be clearly documented. This meant that the service can be assured that information is being translated correctly and understood by the service user.

Staff had access to communication aids to help women become partners in their care and treatment. For example, we observed maternity staff in theatres using visual communication aids to help position women for an epidural.

Women were given a choice of food and drink to meet their cultural and religious preferences.

There was a chapel and a prayer room at the hospital with multi-faith provision.

Access and flow

Women could not always access the service when they needed it and receive the right care promptly.

There was an escalation guideline for maternity bed management, capacity and staffing levels; which described the requirements, triggers and escalation actions for unit closures. We saw that the policy was in date but was in the process of being revised.

Senior leaders reported 23 maternity unit closures from 18 October 2018 to 1 November 2019; closures varied from approximately four hours to two days, with most falling in the range of 12 to 24 hours. The service had attempted to close an additional four times during this period, however, neighbouring trusts were unable to accept women on those occasions. Over the timeframe, a total of 52 women were diverted neighbouring NHS trusts. In addition to the 23 unit closures, the service reported that the birth centre had closed a further nine times.

The home birth service had not been suspended in the last 12 months. Senior leaders said that the on-call community midwives were included in the unit escalation policy, but it was exceptionally rare to bring the community midwives into the unit; and this was confirmed by the community midwifery manager.

We reviewed the most recently available regional maternity dashboard. Maternity dashboard data for the hospital showed that from July 2018 to June 2019, an average of 87.2% of initial antenatal bookings were undertaken before 13 weeks.

Since our last inspection of the service, we saw that an eight-bedded (two, four-bedded bay) induction of labour (IOL) suite had been introduced. Senior leaders reported that this had helped stem the flow of women needing to be cared for on the labour ward, whilst being inducted.

The service had conducted a pilot study / audit to monitor delays in inductions of labour. Data from March to May 2019 showed 66 occasions where women were reported to have waited for augmentation or experienced a delay in the of induction of labour of 12 hours or more over this period. However, the whilst the number of occasions were counted, the service observed that it was not possible to determine the number of women this might have affected (as more than one woman might have been affected per occasion).

The pilot study also included monitoring delays in providing the epidural service. Data from March to May 2019 showed 13 occasions where women waited longer than 30 minutes for an epidural. However, it was not possible to determine if this was due to midwifery staffing or anaesthetist availability.

We requested, but were not provided with NICE staffing ‘red flag’ data, which includes IOL and epidural delay data, for the 12 months prior to our inspection. Senior leaders reported that ‘red flags’ were previously reported via the incident reporting system. The service had implemented a new system and process (the ‘safe care’ acuity tool) in November 2019 to record and monitor NICE staffing ‘red flag’ data, which included IOL and epidural delays. Please see the well-led, information management section of the report.

Managers made sure women could access emergency services when needed; and monitored moves between services. The service monitored all cases where a woman attended the maternity assessment centre (MAC); and data was provided from April 2018 to March 2019. The MAC opened 24 hours a day, seven days a week, in mid-November 2018; and at that time, started to take all calls and attendances. From April 2018 to March 2019, the total number of attendances at the labour ward (1249) and the MAC (7912) was 9161.

Managers and staff worked to make sure women did not stay longer than they needed to. Following our previous inspection of the service we said that the service should consider that sufficient time

was allocated in clinics for the number of patients being seen. At our recent inspection, we saw that the service had been working with the trust transformation team, and had significantly reduced waiting times in specialist clinics, such as the diabetes clinic.

The early pregnancy assessment centre (EPAU) and antenatal day unit (ANDU) offered booked appointments. However, staff in the ANDU said women could sometimes experience long waits, due to the unpredictability of service demands.

Women who attended the MAC were able to call ahead for advice prior to attending, to ensure they were attending the most appropriate service. The service also accommodated 'walk in' patients. Staff we spoke with working in the area said that longer waits were apparent on a weekly basis. However, a system was in place to appropriately triage and prioritise women, to ensure those most in need were assessed and treated in a timely manner.

Managers monitored transfers and followed national standards. From November 2018 to October 2019, 87 women were booked to birth at home and 50 (57.5%) did so. During the same period 49 women were transferred from the community to the hospital. This number included women who had booked to birth at home, and those who had not, but required a transfer to the hospital; for example, because the baby was born before arrival. Of the 49 women who were transferred to the hospital, 28 (57%) were transferred antenatally, 10 (20%) were transferred in labour, and 11 (22%) were transferred postnatally.

We could not ascertain if managers worked to keep the number of cancelled appointments to a minimum. We requested the number of clinic cancellations (in acute and community settings) for the 12 months prior to our inspection. Senior leaders returned information that described antenatal clinics were not 'cancelled' in either community or acute setting, given the nature of required appointments and gestation specific pathways. Different means of covering (midwifery and consultant) clinics were described, should the member of staff allocation not be able to attend. It was noted that midwifery appointments would be 're-scheduled' at the earliest opportunity, and consultant clinic appointments would only be 'rescheduled' if it was safe and appropriate to do so. However, senior leaders did not provide associated 'rescheduling' data.

Staff we spoke with in assessment and outpatient areas said there were processes in place to follow up women who did not attend appointments, either in the community or hospital setting.

Public Health England undertook a screening quality assurance visit of antenatal and new born screening programmes at the trust in March 2019. They found the hospital had a clear policy for following up non-attenders including babies not brought back for appointments (DNA policy), and for managing those that decline screening for infectious diseases in pregnancy.

We saw that managers and staff worked to make sure that they started discharge planning as early as possible and took action to prevent delayed discharges. For example, the service ran a seven-day new-born and infant physical examinations (NIPE) service.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. However, the average time taken to investigate, and close complaints was above (more than double) trust target.

Summary of complaints

The service clearly displayed information about how to raise a concern in patient areas. We saw patient advice and liaison service (PALS) information leaflets on display in the areas we visited. We

also saw trust information leaflets on display in waiting areas about how to make a comment, compliment or complaint.

We also observed 'patient suggestion' boxes in some service areas we visited. These allowed women to suggest improvements or comment on 'lower level' concerns, without formally (directly) raising this with a staff member.

Women, relatives and carers knew how to complain or raise concerns. Patients we spoke with said they would feel comfortable raising a concern with staff or making a complaint, if needed.

Trust level

From August 2018 to July 2019 the trust received 29 complaints in relation to maternity (5.5% percent of the total complaints received by the trust) all of which related to Bradford Royal Infirmary. A breakdown of complaints by type is shown below:

Type of complaint	Number of complaints	Percentage of total
Obstetrics and Gynaecology	21	72.4%
Patient Care including Nutrition/Hydration	4	13.8%
Values and Behaviours (staff)	2	6.9%
Communications	1	3.4%
Prescribing errors	1	3.4%
Total	**29**	**100.0%**

Trust policy was to provide a written response to complainants following an investigation into the issues raised or following a local resolution meeting; within either 30 or 60 working days, depending on the complexity of the complaint. In some circumstances, the trust could agree upon an extended timescale of up to a maximum period of 6 months, where this was warranted and agreed.

Data provided by the trust did not indicate which complaints had agreed response extensions, or the timescales for response (no data was entered in the optional comments section of the data return). As such, for most cases, it was not possible to determine when the service complied with trust policy.

Of data provided by the service, we saw 17 complaints had been investigated and closed over the period. The trust took an average of 73 working days to investigate and close complaints (ranging from two to 239 working days).

Of the 17 complaints, we saw that in 10 cases (59%), the trust investigated and closed complaints within 60 working days.

We saw that in seven cases (41%) the 60-day target was surpassed, and in three of these cases (18% of 17 complaints examined) the 6-month target was surpassed.

It could not be determined how many of the seven cases which surpassed the 60-day target had been granted an extended response time. Nevertheless, in 18% of cases we determined that the service had not met their obligation to close complaints in line with trust policy (a maximum of six months).

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Staff understood the policy on complaints and knew how to handle them. There was a complaints policy and procedure in place, which staff we spoke with were aware of. Staff we spoke with said that they would try to manage complaints locally and immediately address any concerns, wherever

possible. However, if this was not possible, they said they would always advise patients of their right to complain formally; and escalate to their managers.

Several staff we spoke with said that complaints and concerns in the service typically centred around communication issues and perceptions of staff attitudes.

Managers investigated complaints and identified themes. There was a complaints manager for women's services. Complaints and PALS reports were discussed at operational and clinical governance meetings. Within the care group, there was oversight from the head of midwifery, who was supported by governance / complaints officers, if cases were complex.

Managers shared feedback from complaints with staff and learning was used to improve the service. We saw that the complaints manager for women's services had presented a summary of complaints at a recent joint quality and safety specialty meeting (November 2019). Staff we spoke with said learning from concerns and complaints was discussed at safety huddles, handovers, and staff forums.

There was a bi-monthly maternity services multidisciplinary forum. September 2019 meeting minutes detailed actions being taken around appropriate advice given at onset of labour, as there had been a number of complaints with the woman stating, 'nobody told me'. Staff were told to make sure women understood the advice given.

Number of compliments made to the trust

From August 18 to July 2019 there were two compliments received for maternity at Bradford Royal Infirmary (0.2% of all received trust wide). The trust did not supply any extra commentary or relevant additional information within the RPIR regarding compliments.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

However, during our inspection, we observed several documented examples of positive feedback from service users. For example, as detailed in 'thank you' cards displayed in service areas and from patient surveys (please see the caring section of the report for additional information).

Is the service well-led?

Leadership

Leaders had the skills and abilities to run the service; however, they did not always manage, prioritise or robustly monitor key issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Since our last inspection of the service, we saw the trust had reconfigured group and divisional structures. The maternity service was part of the women's division (clinical business unit), which formed part of the planned care group.

A triumvirate comprised of a clinical director, a divisional general manager, and the head of midwifery, led the maternity service. At the time of our inspection, a new clinical director for maternity services was transitioning into post; and was being supported by the existing clinical director, prior to taking up the role.

Three matrons had responsibilities for designated areas within the maternity service. There was a matron with oversight of the birth centre and labour ward, another for antennal clinics and services and the maternity assessment centre, and a matron for inpatient maternity services (antenatal and postnatal wards).

We found that leaders and senior managers in the service had the skills and abilities to run the service; however, they did not always manage, prioritise or robustly monitor key issues the service faced. For example, with respect to identifying and acting on increases in the stillbirth rate, ensuring key audits were being undertaken and acted on, improving levels of one-to-one care in labour and monitoring incident reports of obstetric theatre two use.

Following our inspection, senior leaders reported they had streamlined metrics to be reported to the board and committees; and these included stillbirth rates and levels one-to-one care in labour. In addition, they had added a standing item to the quality committee and board of directors' agenda in relation to maternity services.

For continued oversight, they were also implementing a maternity services oversight group, to be chaired by an executive director and reporting directly to the trust quality committee; to enable a central point for discussion, timely escalation, development and monitoring of an overarching improvement plan.

Day-to-day oversight of service areas were led by ward managers. At least one band seven coordinator was on duty each shift on the labour ward, to support staff and monitor acuity and capacity.

Staff we spoke with said matrons and managers were approachable and visible in the service; and supported staff to develop their skills and take on more senior roles.

All staff said they would feel confident escalating any concerns either to the ward lead or, in their absence, the 'hot desk' midwife.

Vision and strategy

The service did not have an agreed vision for what it wanted to achieve; an overarching strategic vision was being developed following reconfiguration of trust group and divisional structures.

The service did not have an agreed vision for what it wanted to achieve. An overarching strategic vision ('Planed care group 2020') was being developed following reconfiguration of group and divisional structures. Senior leaders reported that this would define transformation priorities for the women's service, and this was being formulated at ongoing workshops.

We saw there was a 'Planned care group, women's services clinical business unit planning 2019-1920' strategy in place. This described general and service specific (including, obstetrics) background information, workforce risks, issues and mitigations, and service aspirations.

We saw the planning strategy noted relevant points from the NHS long term plan. For example, delivering 51% reductions in still birth, maternal mortality, neonatal mortality and serious brain injury nationally by 2025, implementing the saving babies lives care bundle, and rolling out of continuity of carer models.

Workforce risks, issues and mitigations were highlighted; for example, with respect to staffing. However, we saw that no threats were identified to the maternity service delivering on the strategy.

There was an action plan comprised of 17 actions, covering both obstetrics and gynaecology services; with action leads, dates for completion, and progress comments entered. Most anticipated dates for completion were scheduled for 2020 and 2021.

We observed that replacement of the obstetric theatres was absent from the business strategy. However, the strategy document itself was not dated, hence, we could not identify when it was compiled and subsequently approved.

Service aspirations from the strategy included maintaining and developing the maternal and perinatal mental health service, a full-service review of hospital-based outpatient antenatal services, and continuing to develop continuity of carer pathways, models and services to meet national requirements.

Culture

The service had an open culture where patients, their families and staff could raise concerns without fear.

At our recent inspection of the service, we observed closely knit and supportive team dynamics in different areas of the maternity service we visited. Despite the pressures, frontline staff were motivated and positive about the work they did, and the support they provided to women.

Women we spoke with said they would feel comfortable raising a concern with staff or making a complaint, if needed.

Staff felt supported by their line managers and encouraged to develop their skills; however, some staff we spoke with commented that they had been unable to complete training due to cancellation or being redeployed due to staffing acuity.

We saw a maternity workforce update letter had been issued to maternity service staff in September 2019, which indicated that some decisions (staffing redeployment and bed closures) made by the senior leadership team had been questioned. The letter addressed staffing challenges and the need to make difficult choices, and reassured staff that they could reach out to managers and senior leaders if they were concerned or contemplating leaving the service.

Staff we spoke with said they felt able to escalate concerns to managers, or to escalate capacity and acuity concerns to the ‘hot desk’ midwife.

Senior leaders reported there had been no maternity freedom to speak up concerns raised during the 12 months prior to our inspection.

Governance

There were governance structures, processes and systems of accountability to support the delivery of services. However, we were not always assured all levels of governance and management functioned effectively and interacted with each other appropriately. We saw senior leaders had recently implemented new roles to strengthen governance structures within the division.

There were governance structures, processes and systems of accountability to support the delivery of services.

There was a monthly women’s services core group quality and safety meeting; to support the delivery of clinical governance across the speciality. Meetings were chaired by the clinical director for women’s services or head of midwifery, and included the attendance of matrons, directorate managers, risk and governance and specialist midwives, and consultants and medical leads.

Standing agenda items included review of the risk register, education and training compliance, improvement work, the maternity dashboard, guidelines for approval, infection control, patient feedback, and items for escalation.

A maternity service report was submitted on a quarterly basis to the trust quality committee. The aim of the report was to provide the quality committee with an update on the activities of the maternity service, including key risks, improvements and successes.

There were monthly clinical incident panels and morbidity and mortality meetings (please see the incident section of the report) and women's clinical business unit meetings (please see management of risk, issues and performance section of the report).

Women's speciality governance meetings were held on a bi-monthly basis; and held jointly with the neonatal service twice a year. The meeting provided an opportunity for clinicians to present the results of specialist audits, reports, investigations, and research. Attendance was mandatory for all medical staff, unless undertaking critical work. Senior leaders reported that due to the open nature of the meetings, minutes were not taken; agendas were distributed prior to the meetings.

There was a bi-monthly maternity services multidisciplinary forum (formerly the labour ward and postnatal ward forum). The meeting was chaired by a matron, and included representation from obstetricians, anaesthetists, midwives, and a GP representing primary care services. Standing agenda items included birth figures, continuity of carer implementation, mandatory training, , risk management update, national maternity survey, staffing and safe care, and a research update.

However, we were not always assured all levels of governance and management functioned effectively and interacted with each other appropriately.

For example, we found no documented discussion of the stillbirth rate in divisional (women's group) clinical governance meeting minutes we reviewed. Similarly, we could not see that stillbirth rates had been discussed or prioritised as in need of action in the quarterly maternity services report submitted to the trust quality committee. May 2019 maternity services multidisciplinary forum minutes highlighted Bradford as an outlier for stillbirths and/or neonatal deaths, but we could not see this had been escalated (see the patient outcomes section of the report).

Following our inspection, senior leaders that oversight of the stillbirth rate required enhanced monitoring. We saw a case review and risk assessment had been completed, a still birth action plan had been developed, and relevant national audit action plans had been updated. In addition, a new escalation process (ward to board) had been developed from January 2020.

During our inspection, senior leaders reported that they were strengthening governance structures within the division. The service had recently appointed a new band eight risk and governance lead midwife to co-ordinate and oversee the maternity risk, governance and quality agendas. They were supported by an (existing) band seven risk and governance midwife. In addition, senior leaders reported that another (new) band seven risk and governance midwife was to commence employment in December 2019, to support this work.

We also learned that a job plan was in progress to appoint the outgoing clinical director for maternity services to the audit and governance medical lead role within the division; which was vacant at the time of inspection.

Staff we spoke with at all levels conveyed they were clear about their roles and understood what they were accountable for, and to whom.

Management of risk, issues and performance

Leaders and teams did not always use systems to manage performance effectively; and did not always robustly monitor and escalate relevant risks and issues, and identify and implement actions to reduce their impact. The service had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

We found that leaders and teams did not always use systems to identify and monitor risks, and manage performance effectively.

There were arrangements for identifying, recording and managing risks, issues and mitigating actions. However, we observed a mixed picture regarding triumvirate management and prioritisation of key issues the service faced. The triumvirate identified and understood key risks with regards to midwifery staffing, obstetric theatres, and equipment (required renewal of birthing beds); as reflected on the maternity risk register. However, they did not appear cited on other key risks, such as the increase in stillbirth rates, or the status of the clinical audit programme. We also saw they had been slow to respond to improve levels of one-to-one care in labour.

There was a maternity dashboard, which was benchmarked a regional dashboard. However, we were not assured these were being effectively used to identify areas in need of improvement. For example, we reviewed the last three sets of the women's services core group quality and safety meeting minutes and saw the maternity dashboard was a standing agenda for discussion. However, it was only documented as being discussed at the September 2019 meeting, and did not feature in the July or October 2019 meeting minutes (the associated entries being left blank).

The trust had recently developed a new dashboard. However, we observed that there wasn't an associated measure for stillbirths excluding lethal abnormalities. In addition, we could not ascertain if stillbirth indicators (all stillbirths, antenatal stillbirth, intrapartum still birth, and still births at term with low birth rate) were presented in absolute numbers or per 1000 births, as descriptors were not provided. Following our inspection, we saw evidence that a measure for stillbirths excluding lethal abnormalities had been added to the dashboard. However, senior leaders acknowledged the dashboard required further refinement.

There was little assurance that recent increases in stillbirth rates during the 12 months prior to our inspection had been closely monitored, prioritised, escalated and acted on; despite notable differences featured on the regional dashboard between trust stillbirth rates and local averages (please see the governance, and patient outcomes section of the report for additional information).

'Maternal wellbeing' wallets had been purchased for the second consecutive year to reinforce messages around reduced fetal movements. However, other previous efforts to explore and improve the stillbirth rate (for example, as part of the maternal and neonatal health safety collaborative) had taken place in 2017 to 2018, dating to November 2018 (a case study of women presenting with reduced fetal movements) at the latest.

We also observed senior leaders had been slow to act to improve other areas of service delivery. For example, we found levels of one-to-one care in labour had not improved (on average) over the course of at least the last two to three years, and midwifery staffing remained an ongoing issue (see midwifery and nurse staffing section of the report for additional information). The staffing risk had been added to the maternity risk register in May 2019.

Following our inspection, senior leaders had overseen staffing sickness absence and one-to-one care in labour risk assessments, and risk reduction action plans had been developed and implemented. They also reported that the midwifery establishment was to be increased by 5.22 WTE, to enable an additional intra-partum midwife to be on duty per shift. In addition, that from

January 2020, one to one care in labour was to be a performance indicator on the workforce committee and quality committee dashboard.

In addition, we saw that senior leaders had not monitored the use of incident systems to robustly monitor use of obstetric theatre two; which was a key control in the mitigation of associated (please see the incidents section of the report for additional information). Following our inspection, senior leaders reported they were highlighted to the fact that theatre use incident reporting was not happening as per the action plan, and this was now being appropriately completed.

We were not assured that there was a systematic programme of clinical audit in place to monitor quality and to identify where action should be taken. We observed some key maternity service audits had not been conducted or appropriately monitored in the 12 months prior to our inspection (please see information management section, below). Hence, audit action plans could not be produced.

Following our previous inspection of the service, we said the trust should ensure robust actions are in place from audits which will facilitate improvement. Following our recent inspection, we saw limited evidence of leaders using the results of internal and national to improve key patient outcomes. For example, we saw only one of the 12 actions resulting from the MBRRACE-UK 2018 audit (formulated December 2018) was marked as having been completed following our inspection (November 2019).

We also observed action logs in women's services core group quality and safety meeting minutes were frequently not completed, as directed by the template. Meeting minutes themselves were divided by topic area, task, frequency (monthly, quarterly or as required), and action. We saw action notes often had a named lead and detailed tasks to be accomplished. However, none contained specific dates by which actions should be completed. It was therefore difficult to see how the group oversaw and monitored the completion of actions.

The chief nurse at the trust was the board level maternity safety champion. Their remit included frequent (monthly) meetings with maternity safety champions and frontline staff and escalating locally identified safety issues to board level.

We saw the details of monthly board level safety champion meetings for frontline staff to attend were displayed in maternity staff areas we visited.

Staff contributed to decision-making to help avoid financial pressures compromising the quality of care. There was a monthly women's clinical business unit meeting; minutes provided indicated that this had commenced in July 2019. Minutes for July and August 2019 were provided. The group's aim was to ensure a systematic approach to the management of the women's clinical business unit and embedding operational principles to aid quality and performance.

There were trust business community and major incident plans in place.

Information management

The service did not always collect reliable data and analyse it. We were not assured data was always available to understand performance, make decisions and improvements, as we saw some key maternity service audits had not been completed or appropriately monitored. The information systems were integrated and secure.

At our recent inspection of the service we saw staff did not always report incidents as directed, for example, with regard to the use of obstetrics theatre two.

At our previous inspection of the service in 2018, we observed an acceptance around some areas of care and safety when impacted by reduced staffing numbers. At that time, staff reported they would often not complete staffing capacity incident forms; for example, if one-to-one care during labour was

not provided. When asked more about this, staff said it happened so frequently they were no longer reporting this as an incident.

Following our recent inspection, we requested but (except for one-to-one care in labour performance) were not provided with NICE ‘red flag’ incident data for the 12 months prior to our inspection. However, review of ‘pilot’ data and discussions with senior staff and managers suggested ‘red flag’ incident reporting had been limited and inconsistent over this period (see the incidents and evidence-based care and treatment sections of the report for additional information).

Senior leaders reported that an electronic ‘safe care’ acuity tool had been rolled out in November 2019, and systematic recording of red flags (by coordinators) was included in the tool.

Since our last inspection of the service, we saw that ward infection prevention and control audits had been implemented. In addition, that deep dive audits had been conducted because of incidents or never events (such as surgical safety checklists audits), and ongoing risks (such as surveys to gauge theatre infection rates).

However, we were not assured there was a holistic understanding of performance, as we saw some key maternity service audits had not been completed or appropriately monitored. For example, we found a maternity documentation audit had not been completed in the 12 months prior to inspection (see the safe, records section of the report). We also saw the monthly ‘fresh eyes’ audit had not been appropriately completed or monitored in the 12 months prior to inspection (see the safe, assessing and responding to risk section of the report).

Ward accreditation was identified by the service as a mitigating measure. However, we observed audit result measures (individual results within an applicable section) were equally weighted. So, for example, the infection prevention control (IPC) audit for the labour ward was red-green-amber (RAG) rated as green, with 83% compliance achieved. However, measures not compliant included not all (other, local) IPC audits for the previous six months showing compliance to a ‘green’ standard, and only 65.5% of staff being compliant mandatory IPC level two training (as of September 2019). These measures were weighted equally to, for example, staff adhering to ‘bare below the elbows’ dress code. In other applicable measures, we observed that checks routinely involved auditing three patient records to demonstrate compliance. Results from these audits could, therefore, create a false sense of performance and obscure areas in need of improvement; especially when cited in the absence of other (more robust) key audit data.

In addition, the April 2019 to March 2020 maternity audit plan provided following our inspection indicated that a number of other audits (for example, the shoulder dystocia audit) were behind schedule, or their status (for example, the venous thromboembolism (VTE) audit) was not indicated. We also observed idiosyncrasies in the audit plan itself, signifying delays or lack of monitoring in other audit areas (see the evidence-based care and treatment section of the report).

From January 2018 to December 2018 there were 4,960 deliveries were recorded at the trust. However, this figure did not included data where delivery method was 'other' or 'unrecorded'. Staffing papers presented to the trust board detailed that there were 5,387 deliveries in the 2018 calendar year. NHS hospital episode data for January 2018 to December 2018 showed gestation periods were unrecorded for 51.9% of deliveries at the trust, compared to 18.7% nationally.

Following our inspection, in response to our concerns, it was recognised that the service had not always been effective in how they had reported or used data; and measures had been put in place to strengthen collation and oversight of data (please see the governance section of this report).

Information systems were integrated and secure, and the majority of patient records and information in the service (for example, except for manual intrapartum records) were available electronically.

During our inspection senior leaders and managers described they anticipated changing the maternity electronic patient record system, and had arranged demonstrations of other software, as part of the recommissioning process.

We found notifications were consistently submitted to external organisations (such as the Care Quality Commission, and the Health Safety Investigation Branch) as required.

Engagement

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

Trust maternity services were part of the Humber, Coast and Vale (HCV) local maternity system.

Women could give feedback about the service directly; by raising concerns, complaints and compliments. They were also able to offer feedback through friends and family test (FFT) surveys, trust maternity service social media pages, and the maternity voice partnership (MVP).

The Bradford district and Craven maternity voices partnership (MVP) met on a regular basis. There were three main (full) partnership meetings a year, and additional voluntary sector partnership meetings. Themes and issues raised at the voluntary sector partners meeting were fed into the main partners meeting. The voluntary sector meeting usually took places a month prior to the main partnership meeting. Senior maternity leaders at the trust reported they were well represented at the maternity voices partnership (MVP) by midwifery staff.

The service had also arranged bespoke events to capture service user feedback. In October 2019, 81 women and families responded to tell the service about their experience of maternity care at the trust. Following on from this, quarterly feedback sessions had been arranged focusing on different topics. An event in November 2019 focusing on infant feeding.

There had been feedback offered about services from a national bereavement charity.

A continuity of carer patient survey was conducted in July 2019 and 84 women responded, as part of this, levels of satisfaction with the service were assessed, and results were overwhelmingly positive.

We saw an action plan had been developed following the 2018 national maternity survey (developed in January 2019, and updated November 2019); which contained four overarching actions. These centred on ensuring women know to contact their GP if experiencing postnatal concerns, ensuring staff introduced themselves at every encounter, improving the advice given to women at the onset of labour, and improving the attention given to women in labour. Each overarching action had a number of actions to be undertaken; and we observed several actions were ongoing.

Senior leaders reported that the trust 2018 staff survey results were not broken down to clinical business unit (women's services) level. However, a survey was being undertaken (which closed at the end of November 2019), which would include CBU level results, and formulation of a local action plan.

We saw the maternity communication team produced a quarterly newsletter, which was circulated to all maternity staff. This included information about service changes and best practice updates.

The service submitted an example of 'you said, we did' for the antenatal ward. This was labelled as 2019, however, we saw most actions related to late 2018. In addition, we saw many actions were not documented as completed (for example, job adverts were to be issued or relevant meetings were to take place in October 2018) and descriptions indicated leads for some had yet to be identified.

We were informed senior leaders provided email updates to maternity staff on an ad hoc basis. We saw a Maternity Workforce update letter had been issued to maternity service staff in September 2019 by the head of midwifery, in relation to staffing.

The chief nurse at the trust was the board level maternity safety champion. Their role including holding monthly meetings, which maternity staff were invited to attend. Senior leaders also reported that the chief nurse held monthly maternity safety champion walk rounds of the service.

Staff were also invited to attend a variety of meetings and forums; for example, weekly incident case review meetings.

The maternity communication team produced monthly infographics, sharing birth statistics; which were shared both with staff and the public (including on social media).

We saw that senior leaders had collaborated with neighbouring NHS trusts to jointly commission services; for example, with respect to a specialist midwife service for teenage pregnancy and mental health services provision.

We saw that an external review of the trust's antenatal and new-born screening programmes had been undertaken by Public Health England in March 2019.

Learning, continuous improvement and innovation

We found a mixed picture of learning, continuous improvement and innovation. We saw evidence of improvement, innovation and participation in research across numerous maternity service areas. However, we also saw that senior leaders had failed to sufficiently monitor or improve performance in several fundamental areas of maternity service care.

There were systems in place to support improvement, and we saw evidence of improvement and innovation across numerous maternity service areas.

Since our last inspection, the service had implemented an induction of labour suite and a 24/7 maternity assessment centre service (see the access and flow section of the report for additional information).

The service had progressed with its continuity of carer (CoC) agenda. The service exceeded the predicted trajectory for achieving 20% of women booked on a CoC pathway in March 2019, reporting 18.6% in total.

A personalised midwifery case-loading team ('clover') was launched in April 2019, who provided targeted support and care to women in higher-deprivation areas of the locality in the antenatal, perinatal and post-natal period. As part of this work, a specialist midwife for CoC pathways role had been created. The homebirth rate had also been improved following the launch of the Bradford homebirth team (from less than 1% in 2018, to 3% in October 2019).

A multidisciplinary palliative care (butterfly) pathway had been introduced and a new counselling room had been created (see the caring, emotional support section of the report for additional information). We were informed that the service had been nominated and shortlisted for a national award this year, from a strong field of nominations.

We saw a birth options / debrief clinic had also been developed led by a specialist midwife for quality midwifery practice. The clinic offered an additional avenue of support women who had experienced traumatic births and postnatal experiences, or who were higher risk and were requesting care outside of recommended care pathways.

Senior clinicians at the service had been instrumental in driving forward regional maternal enhanced and critical care (MEaCC) projects, which supported the delivery of Enhanced Maternal Care

throughout the regional clinical network. This has included involvement in the regional training offer, and an upcoming data collection project to identify elements of care that improve outcome for women and their babies and reduce length of stay.

We observed the service had recently appointed a specialist midwife for postnatal mental health and complex care, and a clinical risk and governance lead midwife.

We saw that the outcome of antenatal and new-born screening programme review (March 2019) was positive, with good areas of practice identified.

A 'safe care' tool to record NICE 'red flag' staffing incidents had been rolled out in November 2019.

We saw that an external review of the trust's antenatal and new-born screening programmes had been undertaken by Public Health England in March 2019; and the service had responded to the (overwhelming positive) findings be producing an action plan to further improve performance.

Leaders encouraged innovation and participation in research, and we saw that the maternity service had collaborated with a variety of partners and academic units in the 12 months prior to our inspection. We saw evidence of participation in an extensive research portfolio, which included current studies, such as:

- The 'WILL' study, exploring chronic/essential hypertension or gestational hypertension for a timing of delivery;
- 'C-Stich', a study of women at risk of pre-term birth, involving those undergoing cervix length scans due to previous history of miscarriage, previous pre-term birth or cervical surgery; and
- C-Stich-2, a study of women thought to be at imminent risk of miscarriage or pre-term birth; to determine if an emergency cervical cerclage reduces pregnancy loss.

We saw that the service was involved in the 'Better start Bradford' initiative (see the effective, service delivery to meet the needs of local people section of the report). As part of this, the service was working with local and academic partners to track the lives of over 30,000 people in Bradford to find out what influences the health and wellbeing of families.

We also saw evidence of several upcoming studies the service planned to participate in.

Following our recent inspection, we also noted several areas identified for improvement at our last (2018) inspection of the service had been addressed. For example, we saw unit security had been improved, high proportions of midwifery staff had undergone an annual appraisal, mandatory training compliance had improved, maternity policies and guidelines were up to date, fridge temperature monitoring was embedded, and (medicine) patient group directions were up to date. In addition, we saw infection control audits were routinely undertaken, checklists for resuscitaires had been revised, there were quality control checks for fetal blood gas analysers, and patient information leaflets were up to date.

Furthermore, despite being in need of further improvements, we saw positive progress (overall) had been made regarding checking of emergency equipment in accordance with hospital policy.

However, as described, we saw that senior leaders and managers had failed to monitor or improve performance in several fundamental areas of maternity service care.

Following our inspection, senior leaders acknowledged and responded to many of our concerns. This included overseeing reviews, updating or completing risk assessments and implementing mitigating actions; particularly regarding the increased trend in stillbirth rate, midwifery staffing levels (including one-to-one care in labour) and oversight of obstetric theatre two use. As described in the

leadership section of this report, this has included enhanced oversight of maternity performance measures by the division and trust board.

Services for children and young people

Facts and data about this service

The Neonatal Unit (NNU) at the trust has:

- 31 cots: seven level one intensive care cots, seven level two high dependency cots and 17 special care cots. There is a band 7 on duty at all times along with a band 6 sister. Thirteen registered nurses and three support workers provide care each shift. Neonatal advanced nurse practitioners bridge the care between nursing and medical staff. Trainee nursing associates and nursery nurses work alongside the band 5 nurses.

- A nine bedded transitional care unit (TCU) is co-located within the maternity building. The NNU outreach team continue this care and neonatal care with families in the community.

Services for children are provided on three inpatient wards at the Bradford Royal Infirmary site:

- Ward 2 is a day case ward with 15 surgical/medical day case beds and five haematology chairs. Four registered nurses and one support worker provide care. Plastic, ophthalmic, ear nose and throat, maxillary facial and dental surgery theatres operate. Urology surgery and general surgery are provided by visiting paediatric surgeons. An MRI theatre list is also run from the ward.

- Ward 30 and Ward 32 are combined with 35 medical/surgical inpatient/overnight beds, nine short stay beds (24 hours), five assessment cubicles and a stabilisation area.

There is a dedicated paediatric outpatient service located at St Luke's Hospital and this hosts the outreach consultants offering specialist services within Bradford clinics. There are two specialist transition nurses (band 6) supporting children with complex health needs transitioning from child to adult services.

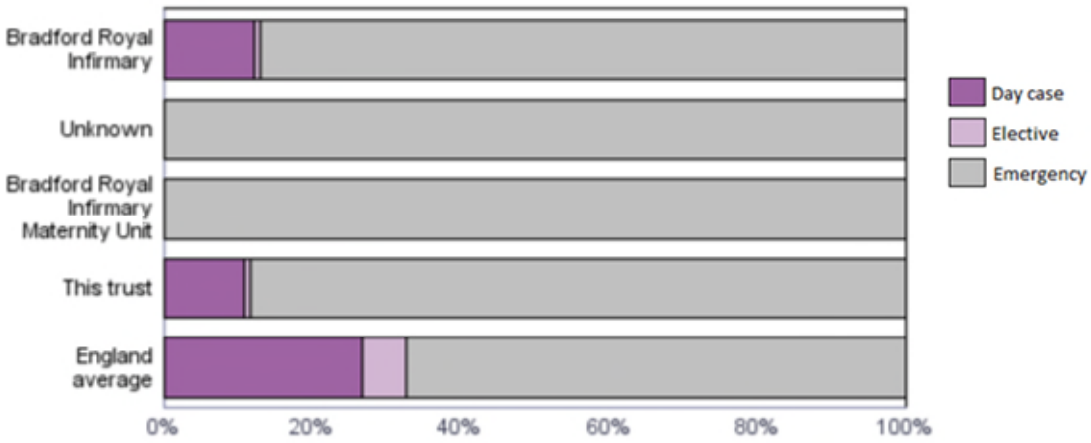
Children's services at St Luke's Hospital also include a child development centre and a community children's nursing team.

(Source: Acute Provider Information Request (RPIR) – AC1. Context acute)

The trust had 11,373 spells from March 2018 to February 2019.

Emergency spells accounted for 88% (10,054 spells), 11% (1,229 spells) were day case spells, and the remaining 1% (90 spells) were elective.

Percentage of spells in children's services by method of admission and site, from March 2018 to February 2019, Bradford Teaching Hospitals NHS Foundation Trust.



Total number of children's spells by site, Bradford Teaching Hospitals NHS Foundation Trust

Site name	Total spells
Bradford Royal Infirmary	10,202
Unknown	1,093
Bradford Royal Infirmary maternity unit	78
This trust	11,373
England total	1,146,418

(Source: Hospital Episode statistics)

Is the service safe?

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Nursing and medical staff received and kept up-to-date with their mandatory training. The mandatory training was comprehensive and met the needs of children, young people and staff.

Three mandatory study days were provided each year for staff to ensure they kept up to date with their mandatory training compliance. One was a matrix study day, which incorporated all the corporate mandatory training, one was a skills day, which was role specific, and one covered paediatric immediate life support (PILS) or paediatric acute illness management (PAIM) training.

Managers monitored mandatory training and alerted staff when they needed to update their training. Practice development nurses were employed who ensured that staff were up to date with their mandatory training.

All staff members displayed an understanding and a non-judgemental attitude towards (or when talking about) patients who had mental health problems or a learning disability. Staff did not receive specific mandatory training to enable them to care for people with a mental health problem or a learning disability. However, the ward manager told us that 16 members of staff had recently received some training on mental health awareness from the local specialist community mental health services for children and young people. We saw evidence of region wide plans for mental health training and education to improve the skills and confidence of acute healthcare staff caring for a child or young person with mental health needs.

The training data supplied below shows mandatory training compliance from April 2018 to March 2019. During our inspection, we saw evidence of up to date compliance with mandatory training. Ward 30/32 had an overall compliance of 94.6%, ward 2 compliance was 97.3% and the neonatal unit had 97.1% compliance. The community nursing compliance was 99.3% and the ambulatory care experience (ACE) team had 93.5% compliance. Outpatient department compliance was 99%. Those staff that had lower levels of compliance were either on long term sick leave or maternity leave.

Mandatory training completion rates
The trust set two different targets of 85% and 95% for completion of mandatory training. These targets were dependant on individual modules.

Trust level

A breakdown of compliance for mandatory training courses April 2018 to March 2019 at trust level for qualified nursing staff in children's services is shown below:

Training module name	April 2018 to March 2019				
	Eligible staff	Staff trained	Completion rate	Trust target	Met (Yes/No)
Corporate Induction	148	148	100.0%	85%	Yes
Infection Control - No Renewal	148	148	100.0%	85%	Yes
Mental Capacity Act Level 1	145	145	100.0%	85%	Yes
Mental Capacity Act Level 2	146	142	97.3%	85%	Yes
Communication Improvement using the SBAR Technique General	143	139	97.2%	85%	Yes
Introduction to Equality & Diversity General	148	143	96.6%	85%	Yes
Safe Administration of Medicines - 2 Year	145	137	94.5%	85%	Yes
Adult Basic Life Support - 1 Year	145	129	89.0%	85%	Yes
NEWS/PAWS/Neo Nate Observation Theory General	142	126	88.7%	85%	Yes
Safe Administration of Medicines - Competence Assessment General	75	66	88.0%	85%	Yes
Diabetes Care and Safe Use of Insulin General	141	122	86.5%	85%	Yes
Conflict Resolution - 3 Years	145	125	86.2%	85%	Yes
Collecting Blood Competency Assessment & Theory - 2 Year	70	59	84.3%	85%	No
Infection Control - 1 Year	148	118	79.7%	85%	No
Venous Thromboembolism - No Renewal	141	112	79.4%	85%	No
Information Governance - 1 Year	148	116	78.4%	95%	No
Moving & Handling Medium/High Risk General	76	55	72.4%	85%	No
NEWS/PAWS/Neo Nate Observation Competence Assessment General	142	97	68.3%	85%	No
Preparing to Administer/Administering Blood - 3 Year	131	84	64.1%	85%	No
Blood Transfusion - 2 Years	131	83	63.4%	85%	No
Organising Receipt of Blood - 3 Year	131	78	59.5%	85%	No
Quality & Diversity for Managers General	4	0	0.0%	85%	No

In children's services the 95% target was not met for the single applicable training module. The 85% target was met for twelve of the remaining 21 mandatory training modules for which qualified nursing staff were eligible.

A breakdown of compliance for mandatory training courses from April 2018 to March 2019 at trust level for medical staff in children's services is shown below:

Training module name	April 2018 to March 2019				
	Eligible staff	Staff trained	Completion rate	Trust target	Met (Yes/No)
Mental Capacity Act Level 1	27	27	100.0%	85%	Yes
Communication Improvement using the SBAR Technique General	28	28	100.0%	85%	Yes
Mental Capacity Act Level 2	1	1	100.0%	85%	Yes
Infection Control - No Renewal	58	57	98.3%	85%	Yes
Introduction to Equality & Diversity General	58	57	98.3%	85%	Yes

NEWS/PAWS/Neo Nate Observation Theory General	28	27	96.4%	85%	Yes
Corporate Induction	58	55	94.8%	85%	Yes
Diabetes Care and Safe Use of Insulin General	28	26	92.9%	85%	Yes
Acute Kidney Injury (AKI)General	28	26	92.9%	85%	Yes
Safe Administration and Preparation of Injectables General	28	26	92.9%	85%	Yes
Dangers of Misplaced Naso Gastric (NG) Tube (NPSA Alert)General	28	25	89.3%	85%	Yes
Naso Gastric (NG) Tube Placement Self Certification General	27	24	88.9%	85%	Yes
Information Governance - 1 Year	58	47	81.0%	95%	No
Blood Transfusion - 2 Years	28	22	78.6%	85%	No
Infection Control - 1 Year	28	21	75.0%	85%	No
Adult Basic Life Support - 1 Year	28	18	64.3%	85%	No

In children's services the 95% target was not met for the single applicable training module. The 85% target was met for 12 of the remaining 15 mandatory training modules for which medical staff were eligible.

Bradford Royal Infirmary children's services

A breakdown of compliance for mandatory training courses April 2018 to March 2019 at Bradford Royal Infirmary for qualified nursing staff in children's services is shown below:

Training module name	April 2018 to March 2019				
	Eligible staff	Staff trained	Completion rate	Trust target	Met (Yes/No)
Corporate Induction	139	139	100.0%	85%	Yes
Infection Control - No Renewal	139	139	100.0%	85%	Yes
Mental Capacity Act Level 1	136	136	100.0%	85%	Yes
Mental Capacity Act Level 2	137	133	97.1%	85%	Yes
Communication Improvement using the SBAR Technique General	134	130	97.0%	85%	Yes
Introduction to Equality & Diversity General	139	134	96.4%	85%	Yes
Safe Administration of Medicines - 2 Year	136	128	94.1%	85%	Yes
NEWS/PAWS/Neo Nate Observation Theory General	136	120	88.2%	85%	Yes
Adult Basic Life Support - 1 Year	136	120	88.2%	85%	Yes
Safe Administration of Medicines - Competence Assessment General	72	63	87.5%	85%	Yes
Diabetes Care and Safe Use of Insulin General	133	115	86.5%	85%	Yes
Conflict Resolution - 3 Years	136	116	85.3%	85%	Yes
Collecting Blood Competency Assessment & Theory - 2 Year	70	59	84.3%	85%	No
Information Governance - 1 Year	139	110	79.1%	95%	No
Venous Thromboembolism - No Renewal	133	105	78.9%	85%	No
Infection Control - 1 Year	139	109	78.4%	85%	No
Moving & Handling Medium/High Risk General	70	50	71.4%	85%	No

NEWS/PAWS/Neo Nate Observation Competence Assessment General	136	91	66.9%	85%	No
Preparing to Administer/Administering Blood - 3 Year	131	84	64.1%	85%	No
Blood Transfusion - 2 Years	131	83	63.4%	85%	No
Organising Receipt of Blood - 3 Year	131	78	59.5%	85%	No
Equality & Diversity for Managers General	4	0	0.0%	85%	No

At Bradford Royal Infirmary children's services the 95% target was not met for the single applicable training module. The 85% target was met for 12 of the remaining 21 mandatory training modules for which qualified nursing staff were eligible.

A breakdown of compliance for mandatory training courses from April 2018 to March 2019 at Bradford Royal Infirmary for medical staff in children's services is shown below:

Training module name	April 2018 to March 2019				
	Eligible staff	Staff trained	Completion rate	Trust target	Met (Yes/No)
Mental Capacity Act Level 1	27	27	100.0%	85%	Yes
Communication Improvement using the SBAR Technique General	28	28	100.0%	85%	Yes
Mental Capacity Act Level 2	1	1	100.0%	85%	Yes
Infection Control - No Renewal	58	57	98.3%	85%	Yes
Introduction to Equality & Diversity General	58	57	98.3%	85%	Yes
NEWS/PAWS/Neo Nate Observation Theory General	28	27	96.4%	85%	Yes
Corporate Induction	58	55	94.8%	85%	Yes
Diabetes Care and Safe Use of Insulin General	28	26	92.9%	85%	Yes
Acute Kidney Injury (AKI)General	28	26	92.9%	85%	Yes
Safe Administration and Preparation of Injectables General	28	26	92.9%	85%	Yes
Dangers of Misplaced Naso Gastric (NG) Tube (NPSA Alert)General	28	25	89.3%	85%	Yes
Naso Gastric (NG) Tube Placement Self Certification General	27	24	88.9%	85%	Yes
Information Governance - 1 Year	58	47	81.0%	95%	No
Blood Transfusion - 2 Years	28	22	78.6%	85%	No
Infection Control - 1 Year	28	21	75.0%	85%	No
Adult Basic Life Support - 1 Year	28	18	64.3%	85%	No

In children's services the 95% target was not met for the single applicable training module. The 85% target was met for 12 of the remaining 15 mandatory training modules for which medical staff were eligible.

St Luke's Hospital children's services

A breakdown of compliance for mandatory training courses April 2018 to March 2019 at St Luke's Hospital for qualified nursing staff in children's services is shown below:

Training module name	April 2018 to March 2019				
	Eligible	Staff	Completion	Trust	Met

	staff	trained	rate	target	(Yes/No)
NEWS/PAWS/Neo Nate Observation Competence Assessment General	6	6	100.0%	85%	Yes
NEWS/PAWS/Neo Nate Observation Theory General	6	6	100.0%	85%	Yes
Mental Capacity Act Level 1	9	9	100.0%	85%	Yes
Adult Basic Life Support - 1 Year	9	9	100.0%	85%	Yes
Mental Capacity Act Level 2	9	9	100.0%	85%	Yes
Conflict Resolution - 3 Years	9	9	100.0%	85%	Yes
Corporate Induction	9	9	100.0%	85%	Yes
Safe Administration of Medicines - 2 Year	9	9	100.0%	85%	Yes
Infection Control - No Renewal	9	9	100.0%	85%	Yes
Safe Administration of Medicines - Competence Assessment General	3	3	100.0%	85%	Yes
Introduction to Equality & Diversity General	9	9	100.0%	85%	Yes
Communication Improvement using the SBAR Technique General	9	9	100.0%	85%	Yes
Infection Control - 1 Year	9	9	100.0%	85%	Yes
Diabetes Care and Safe Use of Insulin General	8	7	87.5%	85%	Yes
Venous Thromboembolism - No Renewal	8	7	87.5%	85%	Yes
Moving & Handling Medium/High Risk General	6	5	83.3%	85%	No
Information Governance - 1 Year	9	6	66.7%	95%	No

At St Luke's Hospital children's services the 95% target was not met for the single applicable training module. The 85% target was met for 15 of the remaining 16 mandatory training modules for which qualified nursing staff were eligible.

There was no medical staff mandatory training compliance data for children's services at St Luke's Hospital supplied by the trust.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Safeguarding

Staff understood how to protect children, young people and their families from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Nursing and medical staff received training specific for their role on how to recognise and report abuse. The safeguarding training incorporated training on female genital mutilation (FGM) and child sexual exploitation (CSE). We saw a flow chart displayed which advised staff of the procedures to follow for suspected domestic violence.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. During our inspection staff took part in safeguarding strategy meetings, arranged to discuss concerns with patients.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff we spoke with told us the safeguarding team were accessible and visited the ward every day to take part in the safety huddle. Whilst we were on inspection we saw the safeguarding nurse present on ward 30/32, providing support to staff and attending a safeguarding strategy meeting.

Young people from the age of 14 years had a choice of whether they were admitted to an adult or children's ward. The safeguarding nurse and matron for children's services were made aware of any admissions to areas other than the children's wards. This allowed them to provide support and have an overview of all children within the hospital. Guidelines were available for when young people were nursed on wards other than the children's wards. Staff in other areas that frequently saw children and young people had dedicated safeguarding training.

The safeguarding team were sent copies of safeguarding referrals, which they reviewed and audited. During our inspection, we saw an appropriate safeguarding referral had been made for a patient with mental health concerns.

The safeguarding nurse told us that safeguarding supervision was on an ad hoc basis. Supervision was offered to discuss individual cases, but there were plans in place to offer 45 minute safeguarding sessions at the end of every safeguarding level three training course.

There were safeguarding champions in all areas, who had been offered additional supervision sessions.

Medical staff attended regular safeguarding peer review sessions. There was a named doctor in the safeguarding team and the designated doctor was based in the hospital. A safeguarding review of cases was held every two weeks.

The electronic patient record contained a flagging system, which alerted staff to any safeguarding concerns. Staff could see whether a child was on a child protection plan or was a looked after child.

Access to and exit from all the wards was via intercom which prevented unauthorised access and ensured children could not leave. An abduction policy was in place and staff we spoke with told us this was regularly tested.

The main children's outpatient department at St Luke's Hospital was not locked, this meant anyone could enter the department. We asked the matron whether this had been risk assessed and they told us that the outpatient environment had been assessed for safety and a number of measures put in place. Some of the consulting rooms had doors to outside areas, these had alarms fitted, a door in to the physiotherapy area had swipe card access fitted and they had fitted two cameras along the corridor to the main door. A missing child and abduction policy was in draft version at the time of our inspection.

Within the safeguarding policy was the procedure to follow for those children that were not brought to appointments.

Safeguarding training completion rates

The trust set a target of 85% for completion of safeguarding training.

Trust level

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 at trust level for qualified nursing staff in children's services is shown below:

Training module name	April 2018 to March 2019				
	Eligible staff	Staff trained	Completion rate	Trust target	Met (Yes/No)
Safeguarding Children Level 1 - 3 Years	148	148	100.0%	85%	Yes
Safeguarding Children Level 2 - 3 Years	148	148	100.0%	85%	Yes
Safeguarding Children Level 3 - 1 Year	148	129	87.2%	85%	Yes
Safeguarding Adults Level 1 - 3 Years	148	125	84.5%	85%	No
Safeguarding Children Level 3 Specialist - 1 Year General	38	30	78.9%	85%	No
Safeguarding Adults Level 2 - 3 Years	147	103	70.1%	85%	No

In children's services, the 85% target was met for three of the six safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 at trust level for medical staff in children's services is shown below:

Training module name	April 2018 to March 2019				
	Eligible staff	Staff trained	Completion rate	Trust target	Met (Yes/No)
Safeguarding Children Level 4 - 1 Year	2	2	100.0%	85%	Yes
Safeguarding Children Level 2 - 3 Years	28	28	100.0%	85%	Yes
Safeguarding Children Level 1 - 3 Years	58	57	98.3%	85%	Yes
Safeguarding Children Level 3 - 1 Year	28	27	96.4%	85%	Yes
Safeguarding Children Level 3 Specialist - 1 Year General	26	25	96.2%	85%	Yes
Safeguarding Adults Level 1 - 3 Years	58	47	81.0%	85%	No

In children's services the 85% target was met for five of the six safeguarding training modules for which medical staff were eligible.

Bradford Royal Infirmary children's services

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 at Bradford Royal Infirmary for qualified nursing staff in children's services is shown below:

Training module name	April 2018 to March 2019				
	Eligible staff	Staff trained	Completion rate	Trust target	Met (Yes/No)
Safeguarding Children Level 1 - 3 Years	139	139	100.0%	85%	Yes
Safeguarding Children Level 2 - 3 Years	139	139	100.0%	85%	Yes
Safeguarding Children Level 3 - 1 Year	139	120	86.3%	85%	Yes
Safeguarding Adults Level 1 - 3 Years	139	117	84.2%	85%	No
389MANDSafeguarding Children Level 3 Specialist - 1 Year General	34	26	76.5%	85%	No
Safeguarding Adults Level 2 - 3 Years	138	96	69.6%	85%	No

At Bradford Royal Infirmary children's services the 85% target was met for three of the six safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 for medical staff in the children's services at Bradford Royal Infirmary is shown below:

Training module name	April 2018 to March 2019				
	Eligible staff	Staff trained	Completion rate	Trust target	Met (Yes/No)
Safeguarding Children Level 4 - 1 Year	2	2	100.0%	85%	Yes
Safeguarding Children Level 2 - 3 Years	28	28	100.0%	85%	Yes
Safeguarding Children Level 1 - 3 Years	58	57	98.3%	85%	Yes
Safeguarding Children Level 3 - 1 Year	28	27	96.4%	85%	Yes
Safeguarding Children Level 3 Specialist - 1 Year General	26	25	96.2%	85%	Yes
Safeguarding Adults Level 1 - 3 Years	58	47	81.0%	85%	No

At Bradford Royal Infirmary children's services the 85% target was met for five of the six safeguarding training modules for which medical staff were eligible.

St Luke's Hospital children's services

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 at St Luke's Hospital level for qualified nursing staff in children's services is shown below:

Training module name	April 2018 to March 2019				
	Eligible staff	Staff trained	Completion rate	Trust target	Met (Yes/No)
Safeguarding Children Level 2 - 3 Years	9	9	100.0%	85%	Yes
Safeguarding Children Level 3 - 1 Year	9	9	100.0%	85%	Yes
Safeguarding Children Level 3 Specialist - 1 Year General	4	4	100.0%	85%	Yes
Safeguarding Children Level 1 - 3 Years	9	9	100.0%	85%	Yes
Safeguarding Adults Level 1 - 3 Years	9	8	88.9%	85%	Yes
Safeguarding Adults Level 2 - 3 Years	9	7	77.8%	85%	No

At St Luke's Hospital children's services the 85% target was met for five of the six safeguarding training modules for which qualified nursing staff were eligible.

There was no medical staff safeguarding training compliance data for children's services at St Luke's Hospital supplied by the trust.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Cleanliness, infection control and hygiene

Staff used equipment and control measures to protect children, young people, their families, themselves and others from infection. They kept equipment and the premises visibly clean. However, infection rates on the neonatal unit had increased over the last couple of years.

Ward areas were clean and had suitable furnishings which were clean and well-maintained. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Staff followed infection control principles including the use of personal protective equipment (PPE). Gloves and aprons were available in all areas and suitable hand washing facilities and hand gel dispensers were readily available. On entry to the neonatal unit there were handwashing facilities, which visitors were asked to use before they entered the unit.

We saw notices above the sinks on the children's wards encouraging children and young people to wash their hands.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We saw 'I am clean' stickers on equipment. We saw completed cleaning checklists for all areas.

We saw results from infection control audits displayed on the neonatal unit. These showed results from audits carried out in October 2019. Insertion of cannula- 96.2%, care of cannula- 95.6%, hand hygiene- 95.1%, insertion of longline and umbilical lines- 93.3%, care of longlines and umbilical lines- 90.1%, suction of ventilated patients- 100% and care of ventilated patient- 99.1%.

The neonatal unit held neonatal infection meetings. We reviewed minutes of the meeting from October 2019, these showed that infection rates had increased over the last couple of years. The target for line associated infection rates was less than 10/1000, the results for the year so far showed line associated infection rates of 16/1000. Bloodstream infections in babies less than 32 weeks was 11.4%. The UK average, taken from the national neonatal audit programme in 2017, was 8%. Actions were in place following the meeting to try to improve the figures, including parental education, additional infection prevention and control team walk rounds, peer review of practice in other units and continued updates for nursing and medical staff on aseptic non-touch technique.

The children's services scorecard for September 2019 showed there had been one hospital attributable case of Clostridium Difficile (C difficile) in June 2019, one in July 2019 and one in September 2019. However, the one case in July 2019 was a readmission of the same patient from June 2019. The trust threshold was two cases in a month, the service was therefore within the threshold.

Between September 2018 and September 2019, there had been five cases of hospital attributable E-coli and one case of hospital attributable MSSA.

Hand hygiene scores for November 2019, in the outpatients department, were 100%.

Most parents we spoke with during the inspection told us they felt the environment was clean, although one mother on the transitional care unit told us the toilet was not very clean.

Isolation procedures were in place for those children and young people with suspected infections. Notices on the doors of cubicles on the children's ward informed staff and visitors of the precautions that should be taken.

CQC Children and Young People's Survey 2016

In the CQC Children and Young People's Survey 2016 the trust scored 8.2 out of ten for the question 'How clean do you think the hospital room or ward was that your child was in?' This was worse than other trusts.

(Source: CQC Children and Young People's Survey 2016, RCPCH)

Environment and equipment

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

Children, young people and their families could reach call bells and staff responded quickly when called.

The design of the environment followed national guidance. The neonatal unit had several multi cot rooms that were spacious and had sufficient space. Two of the rooms were used flexibly and could accommodate high dependency or intensive care babies. The neonatal unit was located next to the delivery suite and was connected via swipe access doors. Each area of the neonatal unit contained a milk fridge, these were not locked, and the milk did not contain tamper proof labels. However, each fridge was located in a multi cot room, which always had a staff member present. Breast milk fridge temperatures were monitored and recorded.

The service had suitable facilities to meet the needs of children and young people's families. During our previous inspections, in 2015 and 2016, concerns were raised about the environment on the children's ward. At this inspection the children's ward (ward 30) and the children's clinical decision area (ward 32) had moved to a new hospital wing, built in 2017. The two areas were connected and run as one unit. All patients and visitors entered and left the wards through the doors for ward 32, as this area had a reception desk where entry and exit could be monitored.

The children's clinical decision unit had five assessment rooms which had privacy smart glass, this meant the glass could be switched from private to transparent, allowing for private consultations to take place and then switched to transparent to enable staff to see inside the cubicle when needed.

The service had enough suitable equipment to help them to safely care for children and young people. Staff carried out daily safety checks of specialist equipment. We saw completed checklists that indicated checks had taken place. A medical engineer was based on the neonatal unit during the week, to provide support for any equipment problems. We saw that all equipment had been electrical tested. However, we found some saturation monitors on ward two that were overdue for testing. We raised this with the staff at the time of our inspection and they arranged to have them serviced the next day.

Resuscitation equipment was available in all areas we visited. We saw that regular checks of the equipment had taken place in most areas to ensure it was safe and ready to use. However, on the transitional care ward we found a resuscitaire which said twice daily checks should be completed. When we looked at the checklist we saw 32 occasions between July and November 2019 when the checklist had not been completed.

In the stabilisation room on the children's unit we found four out of date items, which included two ventilator circuits, a chest drain and a thoracic catheter. We raised this with a staff member at the time of our inspection and they told us they were aware of the out of date items, but they had not been removed. We asked them to remove these items to ensure no one used them in error.

Staff disposed of clinical waste safely. We saw waste was disposed of appropriately. Sharps bins were correctly labelled and not overfull.

Theatre recovery was shared with adult patients, but there was a dedicated area for children and young people, which could be screened or curtained off.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each child and young person and removed or minimised risks. Staff identified and quickly acted upon children and young people at risk of deterioration.

Staff used a nationally recognised tool to identify children or young people at risk of deterioration and escalated them appropriately. Staff used the paediatric advanced warning score (PAWS) to identify those children at risk of deterioration. Staff told us since they had moved to an electronic patient record, a PAWS score was not calculated unless a full set of observations had been completed, including a blood pressure. A risk assessment had been completed following the introduction of the electronic patient record and nurses were able to manually calculate a PAWS score without the blood pressure and were given a hand-held card to quickly establish the escalation required for the score recorded. In February 2019, it was agreed that a blood pressure reading would be performed with every set of observations, allowing the full score to be generated in the patient record. Following a recent incident, it had been identified there were still gaps in the recording of blood pressures, all staff had been told they must complete a blood pressure with the observations to ensure a PAWS score was calculated. If a blood pressure could not be obtained, it should be documented why. We saw a spot check audit, completed in November 2019, which checked nursing staff awareness of the policy. This showed, out of eight staff members asked, all knew when they should be recording blood pressures and what to do if they could not obtain a blood pressure. In two out of eight records we reviewed, we saw a number of occasions when the PAWS score had not been calculated due to a blood pressure not being done. However, it was not always documented as to why a blood pressure could not be done. We saw that children had been appropriately escalated where necessary. Results from safety thermometer data showed 96.9% completion of PAWS in July 2019, with 96.9% appropriately escalated. In August 2019, there was 100% completion and 87% appropriately escalated. In September 2019, 97.6% were appropriately completed and 100% appropriately escalated. In October 2019, there was 100% completion and 91.4% appropriately escalated.

Observations were completed for all neonates on the neonatal unit. These were monitored on a regular basis and staff were able to identify any change in clinical condition. However, regular observations were not carried out on neonates on the transitional care ward but were done based on clinical need. There was no early warning tool used on the transitional care ward, staff told us there was always a neonatal nurse working on the ward, who would recognise any deterioration in a child's condition.

Staff completed risk assessments for each child and young person on admission using a recognised tool. Risk assessments were completed related to nutrition, skin and pressure ulcer risk, moving and handling and peripheral intravenous access assessments.

Staff knew about and dealt with any specific risk issues. Staff used a sepsis screening tool. This was a paper record that was scanned on to the patient record, as it had been found that the electronic patient record sepsis screening tool required three abnormal parameters to trigger. Staff we spoke with told us all children admitted should have a sepsis screening tool started. We reviewed patient records and found that staff had started a sepsis screening tool for a child admitted with suspected sepsis, but the whole form had not been completed. However, we saw that the child had been treated appropriately, had received antibiotics within one hour of arrival and all care and treatment had been documented within the electronic patient record. Children's services quality dashboard information showed an improvement in sepsis screening. In October 2019, 100% of

admissions had a sepsis screening tool completed on the inpatient ward (ward 30) and 95% of admissions to the clinical decisions area (ward 32) had a sepsis screening tool completed.

Children requiring higher dependency care or transfer to a paediatric intensive care unit were cared for in the stabilisation room. The stabilisation room contained two bed spaces to care for children. Appropriately trained staff cared for the children in this area. Staff completed a critical care skills passport and care of the deteriorating child training, along with European paediatric life support (EPLS) training. Staff rotas were organised so that there was always a suitably trained nurse on duty to cover the stabilisation unit. Data provided by the trust showed that at the end of March 2019, 100% of staff covering the stabilisation room had completed EPLS training, 32% had completed year one of the critical care passport and 24% had completed year two.

Eighty eight percent of nursing staff on the ward had attended a multi-disciplinary Paediatric Resuscitation and Stabilisation (PReS) day, run and provided by the Yorkshire and Humber Paediatric Critical Care Operational Delivery Network (Y&H PCCODN). Eighty eight percent of staff had also attended a paediatric acute illness management (AIM) course.

The anaesthetists were responsible for care of the patient on a ventilator and would stay on the unit to care for any child that required ventilating until transfer took place. The regional transport service was used to transport children requiring intensive care.

Policies were in place for the stabilisation and transfer of children, including the procedure for children requiring intensive care when there were no intensive care beds, or the transfer was delayed.

The nurses station contained central monitors, so staff could see individual patients observations and were aware of deviations in observations.

Nurses on the neonatal unit had completed neonatal life support training and sepsis was covered in their infection prevention and control training.

The ambulatory care experience (ACE) service had criteria for referral and exclusions. Staff completed PAWS and sepsis tools and had a process for escalation of unwell children. Staff from the ACE team attended three huddles a day with consultants to discuss the children in their care and contacted the consultant for advice when needed. Children under the care of the ACE team had 24-hour open access to the clinical decisions area if needed.

In the children's outpatient department at St Luke's Hospital staff told us they would put out a 'crash' (resuscitation) call for a deteriorating child if they needed to, they would then ring 999 to transfer the child to Bradford Royal Infirmary. Staff would complete observations and a PAWS chart.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a child or young person's mental health). Staff we spoke with told us that the trust had good working relationships with staff working in local specialist community mental health services for children and young people. Following an incident of self-harm, staff working in local specialist community mental health services for children and young people would attend to assess the patient only after a 24-hour 'cooling off period'. Managers told us that this was to ensure that patients were rested and medically fit for assessment.

During the inspection we assessed how the trust provided mental healthcare in an acute setting. We reviewed the care records of one patient who had been admitted following an incident of self-harm.

The trust had a risk assessment and management document to support staff to safely manage patients at risk of harm to self or others. Staff had not completed a risk assessment or risk management plan for the patient during their admission.

Staff we spoke with told us that the patient was under constant observations to safely manage the patient's risk of harm to self. Staff also told us that the room allocated to the patient had been modified to remove high risk items which could be used as a ligature. However, the patient's observation level and the environmental adaptations were not recorded in the patient's care plan. Staff did not receive specific training to enable them to observe patients appropriately. During our tours of the ward we observed that the staff member allocated to observe the patient did not maintain observations on several occasions. We raised this with the ward manager who told us that this would be raised with all staff.

Staff shared key information to keep children, young people and their families safe when handing over their care to others. Shift changes and handovers included all necessary key information to keep children and young people safe. Safety huddles were held every morning. These were multidisciplinary huddles attended by staff from all children's wards. Issues discussed included bed base, number of empty beds, number of high acuity patients, staffing and safeguarding.

We saw completed surgical safety checklists, for those children who had undergone surgery.

CQC Children and Young People's Survey 2016

In the CQC Children and Young People's Survey 2016 the trust scored 7.9 out of ten for the question 'Were the different members of staff caring for and treating your child aware of their medical history?' This was about the same as other trusts.

(Source: CQC Children and Young People's Survey 2016, RCPCH)

Nurse staffing

The service overall had enough nursing staff with the right qualifications, skills, training and experience to keep children, young people and their families safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction. However, nurse staffing on the neonatal unit was not meeting national standards, with only 48.6% of shifts from September 2018 to October 2019 compliant with British Association of Perinatal Medicine (BAPM) standards.

The children's service used the children and young people's safer nursing care tool to make decisions on staffing using patient acuity and dependency. Although the children's unit did not work to the Royal College of Nursing (RCN) guidance for staffing of one nurse to three children aged under two, and one nurse to four children aged over two, they worked to a ratio of one nurse to five patients. Staffing numbers and acuity of patients was looked at every morning in the safety huddle and adjustments made if needed. An escalation process was in place and beds were closed to ensure nurse to patient ratios did not exceed one to five. Staff we spoke with told us they felt staffing levels were good and they never had more than five patients.

A senior staffing judgement red, amber, green (RAG) status report was completed each week day by the matrons, outlining staffing numbers, issues and solutions for all inpatient children's services areas.

The children's services met the RCN core standards for staffing, having a minimum of two registered children's nurses at all times in all inpatient and day case areas, at least one staff member on every shift trained in EPLS/APLS and the shift supervisor was supernumerary. One staff member was rostered on every shift to attend the stabilisation room if needed.

The children's unit had a band seven nurse who worked Monday to Friday. There were always two band six nurses on weekends and night shifts.

On the neonatal unit, the nurse in charge was supernumerary and around 70% of staff were qualified in speciality, in line with national guidance. British Association of Perinatal Medicine (BAPM) standards recommend staffing levels in neonatal units to provide 1:1 for intensive care babies, 1:2 for high dependency babies and 1:4 for special care babies. Staff told us they did not always achieve the BAPM standards for staffing, but patient acuity was always taken in to consideration. Data provided by the trust showed 48.6% of shifts from September 2018 to October 2019 were BAPM compliant. The national average for BAPM compliance for this period of time was 56%.

The children's unit had three advanced paediatric nurse practitioners and the neonatal unit had two advanced neonatal nurse practitioners. Advanced nurse practitioners are highly experienced and knowledgeable nurses able to use clinical judgement and autonomous decision making in relation to the assessment, diagnosis, management and evaluation of care.

The children's service employed one nursing associate and had another three that were due to qualify in December.

The children's community nursing team had 22 qualified nursing staff and 18 healthcare support workers. Staff we spoke with told us that the community nurses worked on the word to provide cover when needed.

The ACE team consisted of two team leaders, three permanent staff nurses and three staff nurses that also worked for the community nursing team.

Trust level

The table below shows a summary of the nursing staffing metrics in children's services at trust level compared to the trust's targets, where applicable:

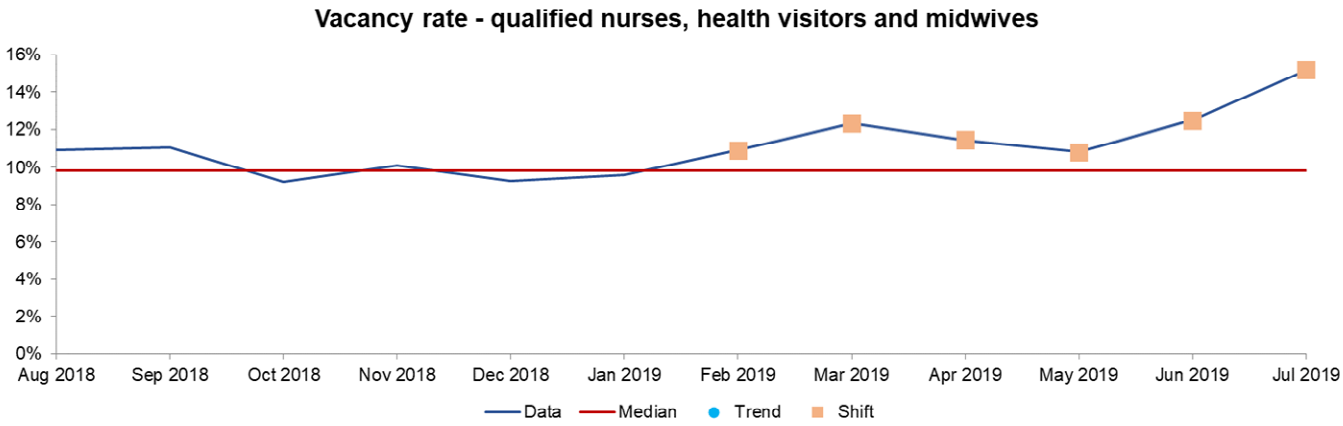
	Children's services annual staffing metrics						
	August 2018 to July 2019						
Staff group	**Annual average establishment**	**Annual vacancy rate**	**Annual turnover rate**	**Annual sickness rate**	**Annual bank hours (% of available hours)**	**Annual agency hours (% of available hours)**	**Annual unfilled hours (% of available hours)**
Target		N/A	N/A	4.5%			
All staff	356.4	10.7%	11.6%	5.1%			
Qualified nurses	180.9	11.1%	12.5%	4.6%	24,653 (9%)	6,044 (2%)	14,468 (6%)

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing bank agency tabs)

Nurse staffing rates within children's services were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover or

sickness or bank use.

Vacancy rates

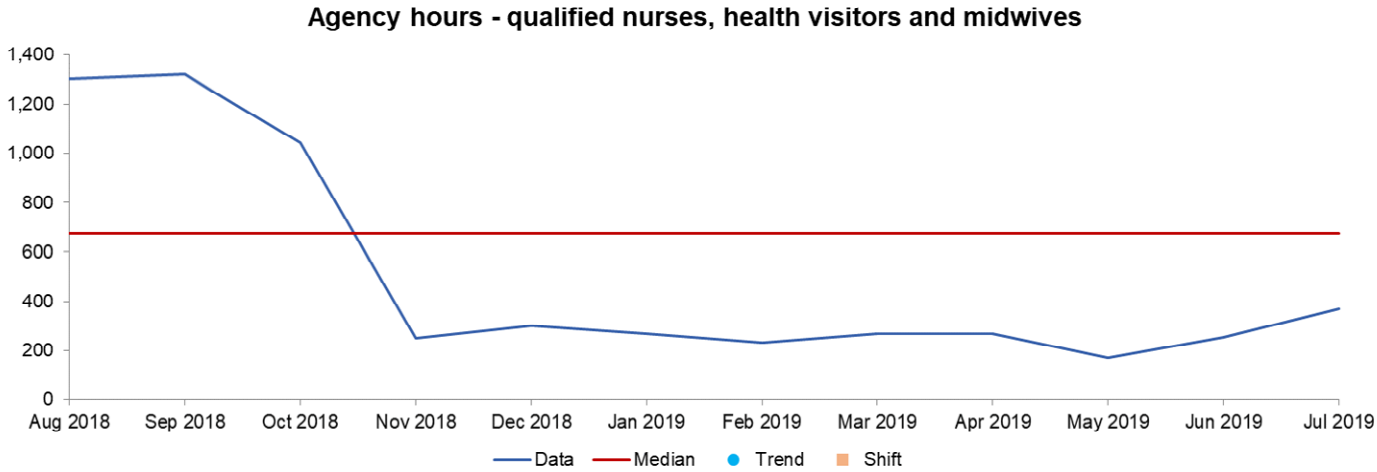


Monthly vacancy rates over the last 12 months for qualified nurses, health visitors and midwives shows a shift from February 2019 to July 2019. This could be an indicator of change.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Agency staff usage

The service had low rates of bank and agency nurses.



Monthly agency hours over the last 12 months for qualified nurses, health visitors and midwives are not stable and may be subject to ongoing change.

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

Managers limited their use of bank and agency staff and requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service.

Bradford Royal Infirmary

The table below shows a summary of the nursing staffing metrics in children's services at Bradford Royal Infirmary compared to the trust's targets, where applicable:

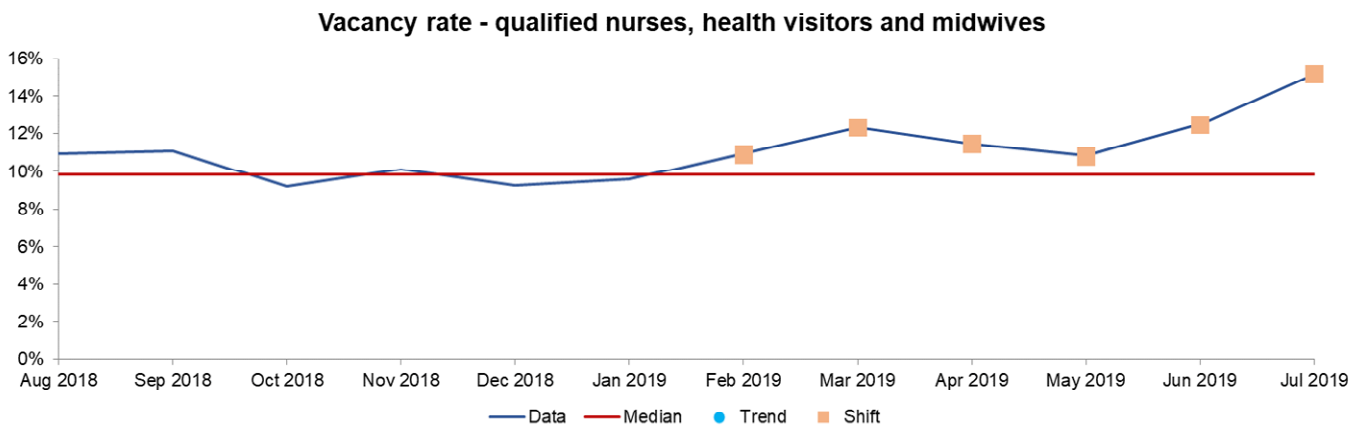
	Children's services annual staffing metrics August 2018 to July 2019						
Staff group	**Annual average establishment**	**Annual vacancy rate**	**Annual turnover rate**	**Annual sickness rate**	**Annual bank hours (% of available hours)**	**Annual agency hours (% of available hours)**	**Annual unfilled hours (% of available hours)**
Target		N/A	N/A	4.5%			
All staff	356.4	10.7%	11.9%	5.3%			
Qualified nurses	180.9	11.1%	12.6%	5.0%	N/A*	N/A*	N/A*

NOTE*: The trust was unable to specify their bank and agency usage at site level.

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing bank agency tabs)

Nurse staffing rates within children's services at Bradford Royal Infirmary were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover, bank or agency use.

Vacancy rates

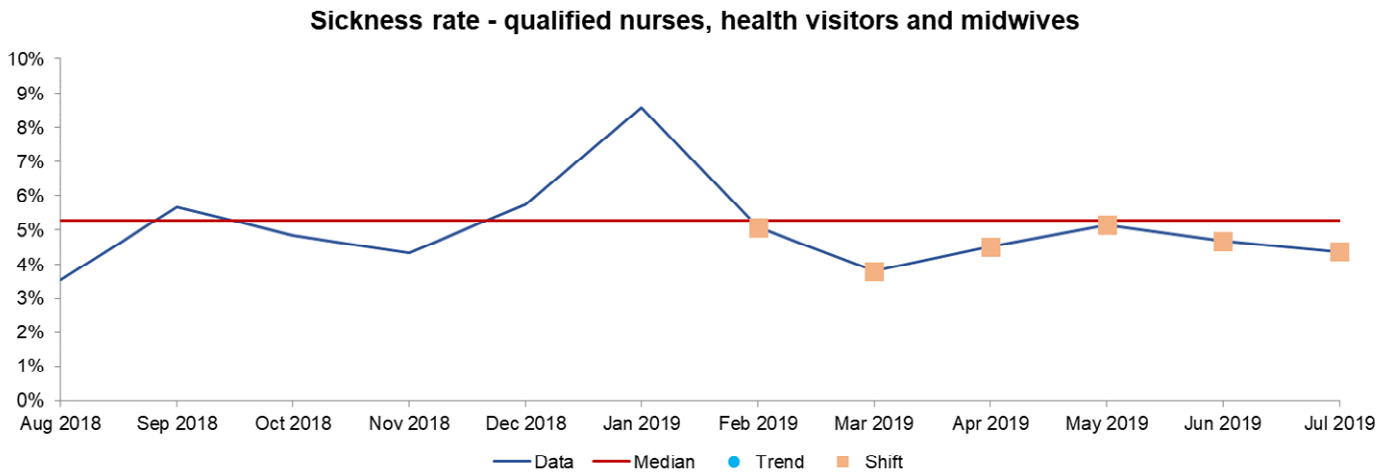


Monthly vacancy rates over the last 12 months for qualified nurses, health visitors and midwives shows a shift from February 2019 to July 2019. This could be an indicator of change.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

During our inspection we were told there were five vacancies for qualified staff and one healthcare assistant vacancy on the children's unit (ward 30/32). Ten newly qualified nurses had recently been recruited and more adverts were going to be posted for the remaining vacancies.
There were ten vacancies on the neonatal unit.
Agency staff were used to cover vacancies when the gaps could not be covered with their own staff.
The children's community nursing team had a 0.9 whole time equivalent band five vacancy.

Sickness rates



Monthly sickness rates over the last 12 months for qualified nurses, health visitors and midwives shows a shift from February 2019 to July 2019. This could be an indicator of change.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

St Luke's Hospital

The table below shows a summary of the nursing staffing metrics in children's services at St Luke's Hospital compared to the trust's targets, where applicable:

	Children's services annual staffing metrics August 2018 to July 2019						
Staff group	**Annual average establishment**	**Annual vacancy rate**	**Annual turnover rate**	**Annual sickness rate**	**Annual bank hours (% of available hours)**	**Annual agency hours (% of available hours)**	**Annual unfilled hours (% of available hours)**
Target		N/A	N/A	4.5%			
All staff	N/A*	N/A*	10.6%	4.6%			
Qualified nurses	N/A*	N/A*	12.0%	2.8%	N/A*	N/A*	N/A*

NOTE*: The trust was unable to specify their establishment, vacancy, bank and agency usage at site level for St Luke's Hospital.

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing bank agency tabs)

Nurse staffing rates within children's services at Bradford Royal Infirmary were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover or sickness.

Medical staffing

Consultant cover on the neonatal unit was not meeting national standards. Paediatric consultant presence on the children's unit was not in line with national standards and not all patients were seen by a consultant within 14 hours of admission. However, the service had prioritised consultant presence during the day, providing consultant cover for the inpatient ward and the clinical decisions area.

There were separate rotas for the paediatric unit and the neonatal unit, which was in line with national guidance. British Association of Perinatal Medicine (BAPM) standards require neonatal intensive care units to have all staffing roles limited to neonatal care at all levels. All tier three consultants should be identified neonatal specialists. However, the BAPM standards require a minimum of seven consultants on the on-call rota, there were only six consultants on the neonatal unit. Daily ward rounds took place, but the consultant did not see the babies requiring special care every day. Nurse led ward rounds took place for the special care babies, with any issues escalated to the consultant, with medical ward rounds held twice a week.

There were 17 consultants for acute paediatric care and seven community paediatricians. The children's unit was covered by two consultants during the day. One consultant covered the inpatient ward (ward 30) and one covered the clinical decision area (ward 32) from 8.45am until 5pm. After 5pm there was one consultant on call. The Royal College of Paediatrics and Child Health (RCPCH) standards say that a consultant paediatrician should be available during times of peak activity, seven days a week, with an expectation that this would be a minimum of 12 hours a day. Medical staff told us that they had prioritised having two consultants providing cover until 5pm, rather than providing cover after 5pm. They were working towards having consultant cover from 5pm until 9pm. The service always had a consultant on call during evenings and weekends.

The RCPCH standards state that every child with an acute medical condition admitted to a paediatric department should be seen by a healthcare professional on the middle grade rota within four hours of admission and within 14 hours of admission by a paediatric consultant. Whilst the service was generally meeting the four hour standard, we were told that every child was not necessarily reviewed by a consultant within 14 hours of admission but had consultant oversight. All children were seen on a ward round by a middle grade healthcare professional and discussions took place with the consultant. Priority was given to the consultant seeing those children most unwell and those that could be discharged.

There were two consultant vacancies and one consultant was on maternity leave. Two locums had been made substantive and the service was looking at a collaboration with a neighbouring trust.

Overnight there was a single middle grade who covered the ward, clinical decisions area and critically unwell children in the emergency department. This meant if the middle grade was called to see a child in the emergency department, the ward and clinical decisions area was left without middle grade cover. A risk assessment had been completed for this and extra middle grade cover was provided until 11pm. The paediatric consultant attended overnight when there was significant issue with patient flow or increased patient acuity.

Trust level

The table below shows a summary of the medical staffing metrics in children's services at trust level compared to the trust's targets, where applicable:

	Children's services annual staffing metrics						
	August 2018 to July 2019						
Staff group	**Annual average establishment**	**Annual vacancy rate**	**Annual turnover rate**	**Annual sickness rate**	**Annual bank hours (% of available hours)**	**Annual locum hours (% of available hours)**	**Annual unfilled hours (% of available hours)**
Target		N/A	N/A	4.5%			

All staff	356.4	10.7%	11.6%	5.1%			
Medical staff	64.4	-1.7%	3.6%	1.5%	310 (<1%)	470 (<1%)	440 (<1%)

Note: The negative vacancy rate indicates that there were more WTE in post than originally scheduled.

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)

Medical staffing rates within children's services were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy, turnover, sickness or locum and agency use.

Bradford Royal Infirmary

The table below shows a summary of the medical staffing metrics in children's services at Bradford Royal Infirmary compared to the trust's targets, where applicable:

	Children's services annual staffing metrics August 2018 to July 2019						
Staff group	**Annual average establishment**	**Annual vacancy rate**	**Annual turnover rate**	**Annual sickness rate**	**Annual bank hours (% of available hours)**	**Annual locum hours (% of available hours)**	**Annual unfilled hours (% of available hours)**
Target		N/A	N/A	4.5%			
All staff	356.4	10.7%	11.9%	5.3%			
Medical staff	64.4	-1.7%	3.6%	1.5%	N/A*	N/A*	N/A*

NOTE*: The trust was unable to specify their bank and agency usage at site level.
Note: The negative vacancy rate indicates that there were more WTE in post than originally scheduled.

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)

Medical staffing rates within children's services at Bradford Royal Hospital were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy, turnover, sickness, bank use or agency use.

St Luke's Hospital

There was no medical staffing data for children's services at St Luke's Hospital supplied by the trust.

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)

Staffing skill mix

There were middle grade staffing gaps. Gaps were covered with locum staff and advanced paediatric nurse practitioners worked on the middle grade rota.

In May 2019, the proportion of consultant staff reported to be working at the trust was slightly higher (49%) than the England average (44%) and the proportion of junior (foundation year 1-2) staff was similar (7%) compared to the England average (6).

Staffing skill mix for the 60 whole time equivalent staff working in services for children and young people at Bradford Teaching Hospitals NHS Foundation Trust

	This Trust	England average
Consultant	49%	44%
Middle career^	4%	7%
Registrar Group~	41%	43%
Junior*	7%	6%

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen speciality
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Records

Staff kept detailed records of children and young people's care and treatment. Records were clear, up-to-date and easily available to all staff providing care. However, paper records on the neonatal unit were not stored securely.

Patient notes were comprehensive, and all staff could access them easily. Patient records on the children's unit were electronic patient records. The only paper records they held were copies of sepsis tools, which were then scanned on to the patient's electronic record.

Records on the neonatal unit were electronic and paper records. Paper records were not stored securely but were kept at the bedside. However, there was always a staff member present in the rooms.

Staff on the wards were unable to access the records system used by the mental health trust, the only way to access them was through the mental health liaison service. This meant that staff may not have the full information related to a young person's mental health.

Community nursing teams used a different electronic patient record than the inpatient wards. However, they were able to access the inpatient record system, so they had access to up to date information. Staff told us the trust was looking at whether it was possible for the inpatient teams to be able to access the system the community teams used to view community records.

The electronic patient record had a system to flag those children with additional needs, such as safeguarding, looked after children and learning disabilities.

Electronic discharge letters were sent to GPs.

Medicines

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Medicines were prescribed and recorded on the electronic patient record.

Staff reviewed children and young people's medicines regularly and provided specific advice to children, young people and their families about their medicines. A paediatric pharmacist visited the children's unit daily and a neonatal pharmacist attended the daily ward round.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. We reviewed fridge temperature recordings and controlled drug documentation. We saw all checks had been completed as required. Medicines were stored in locked cupboards and rooms, all medicines we saw were in date.

We saw patient group directions (PGDs) that were signed and in date. PGDs provide a legal framework that allow some registered health professionals to supply and/or administer specified medicines to a pre-defined group of patients, without them having to see a prescriber.

The children's unit had recently appointed a Senior Assistant Technical Officer (SATO) following a three month pilot. This would reduce the time taken to produce a completed discharge prescription and increase the number of take home medications written the day before discharge. The SATO had not started at the time of our inspection.

In the CQC Children and Young People's Survey 2016 the trust scored 9.6 out of ten for the question 'Were you given enough information about how your child should use the medicine(s) (e.g. when to take it, or whether it should be taken with food)?' This was about the same as other trusts.

(Source: CQC Children and Young People's Survey 2016, RCPCH)

Incidents

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

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust/provider policy. Incidents were reported using an electronic reporting system.

Weekly risk meetings took place where incidents were discussed. Staff received feedback about incidents through the safety huddle, newsletters and a weekly learning poster.

Never Events

The service had no never events on any wards.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From August 2018 to July 2019, the trust did not report any never events for children's services.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

Trust level

In accordance with the Serious Incident Framework 2015, the trust reported one serious incident (SIs) which met the reporting criteria set by NHS England from August 2018 to July 2019. This occurred in June 2019 at Bradford Royal Infirmary and regarded a diagnostic delay incident.

(Source: Strategic Executive Information System (STEIS))

Staff reported serious incidents clearly and in line with trust policy. Staff understood the duty of candour. They were open and transparent, and gave children, young people and their families a full explanation if and when things went wrong. We reviewed the serious incident report and found duty of candour had been completed.

Managers debriefed and supported staff after any serious incident. Staff received feedback from investigation of incidents, both internal and external to the service. Staff gave us an example of a serious incident that had happened. They told us a meeting had taken place to provide support for the staff and to inform them of immediate action that needed to be taken following the incident.

Safety thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, children, young people, their families and visitors.

The safety thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Safety thermometer data was displayed on wards for staff, children, young people and their families to see. We saw information displayed outside the children's unit for October 2019 which showed 100% harm free care for ward 30. Data collected included PAWS audits, pressure ulcers, pain and extravasation. Ward 32 had achieved 100%, apart from PAWS completion, which was 93%.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. The service had been accredited under the Baby Friendly Initiative.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. We reviewed nine policies and guidelines during our inspection. We found them all to be within review dates and referenced national guidance, such as National Institute for Health and Care Excellence (NICE).

The neonatal unit had achieved accreditation under the Baby Friendly Initiative and was the first level three neonatal unit in the UK to achieve accreditation. The Baby Friendly Initiative is a nationally recognised mark of quality care that recognises those services that support families with feeding and developing close relationships, ensuring all babies get the best possible start in life.

Staff on the neonatal unit told us they were working towards Bliss accreditation. The Bliss Baby Charter was designed to standardise high quality family centred care across the UK.

Nutrition and hydration

Staff gave children, young people and their families enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for children, young people and their families' religious, cultural and other needs.

Staff made sure children, young people and their families had enough to eat and drink, including those with specialist nutrition and hydration needs. Specialist support from staff such as dieticians was available for children and young people who needed it. A dietician visited the neonatal unit twice a week.

Nutritional choices had improved following feedback from children, parents and staff on the inpatient ward.

Staff fully and accurately completed children and young people's fluid and nutrition charts where needed.

Staff used a nationally recognised screening tool to monitor children and young people at risk of malnutrition.

The service ensured those mothers that were breastfeeding or expressing were provided with meals whilst they were staying with their babies. On the neonatal unit, a breastfeeding room was available, where mothers could go to express their breastmilk in private.

Cold drinks were available for those waiting in the children’s outpatient department.

Pain relief

Staff assessed and monitored children and young people regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

The children's service had a pain action plan in place from August 2019, following a review of the paediatric safety thermometer results, which highlighted concerns with the number of patients reporting pain issues.

Staff assessed children and young people's pain using a recognised tool and gave pain relief in line with individual needs and best practice. Pain assessments were incorporated in the electronic patient record.

Children and young people received pain relief soon after requesting it. We did not speak to anyone during our inspection that said they had to wait for pain relief.

Staff prescribed, administered and recorded pain relief accurately. A patient group direction (PGD) had been developed to allow nursing staff to administer paracetamol and ibuprofen without having to wait for a doctor to prescribe it.

The neonatal unit used various methods to try to control pain, including sucrose and breastmilk. Sucrose or breastmilk have been found to be effective in reducing procedural pain in preterm and term infants.

The hospital had a pain team who were available to provide support to staff if needed.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and generally achieved good outcomes for children and young people. However, the service was an outlier in the paediatric diabetes audit for case adjusted mean HbA1c.(HbA1c is the average blood sugar levels for the last two to three months. A high HbA1c means there is too much sugar in someones blood)

The service participated in relevant national clinical audits. Managers used information from the audits to improve care and treatment.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. An audit plan was in place for the year ahead.

Paediatric diabetes audit

The service was an outlier for the case adjusted mean HbA1c. An action plan had been developed, with all actions due for completion by January 2020. The diabetes team had been involved in a quality improvement project, which they reported had seen mean HbA1c reduce from 75.1 in 2016/2017 to 69.1 in 2018/2019.

The table below summarises St Luke's Hospital performance in the 2018 National Paediatric Diabetes Audit report.

Metrics *(Audit measures)*	**Trust performance**	**Comparison to other hospitals**	**Met national standard?**
Completion rate for key health checks for patients aged 12+ *(There are seven key care processes recommended by NICE for patients with Type 1 diabetes that should be performed at least annually)*	81.1%	Within expected range	No current standard
Case-mix adjusted mean HbA1c	72.6	Worse than	No current

(*HbA1c levels are an indicator of how well an individual's blood glucose levels are controlled. This measure is provided for benchmarking against other providers during an audit year)*		expected	standard
Median HbA1c *(This measure is provided to give an indicator of how performance has changed between the previous and latest audit reports. A change of 1 mmol/mol is deemed to be clinically significant)*	70.0	No significant change	No current standard

(Source: National Paediatric Diabetes Audit)

National Neonatal Audit Programme

The table below summarises Bradford Royal Infirmary's performance in the 2018 National Neonatal Audit Programme report against measures related to neonatal care.

Metrics ***(Audit measures)***	**Hospital performance**	**Comparison to other hospitals**	**Met national standard?**
Do all babies <32 weeks gestation have a temperature taken within an hour of admission that is 36.5ºc-37.5ºc? (*Low body temperature on admission is associated with increased complications, such as hypoglycaemia, jaundice and respiratory distress, and death in pre-term infants)*	70.6%	Better than expected	Did not meet
Is there a documented consultation with parents by a senior member of the neonatal team within 24 hours of admission? *(Timely consultation with parents/carers is crucial to allaying fear and anxiety and improves the parent/carer experience)*	92.7%	Within expected range	Did not meet
Do all babies < 1501g or a gestational age of < 32 weeks at birth receive appropriate screening for retinopathy of prematurity (ROP) (*ROP is a preventable cause of blindness in pre-term infants provided it is detected and treated in a timely way)*	98.2%	Within expected range	Did not meet
Do all babies with a gestation at birth <30 weeks receive a documented follow-up at two years gestationally corrected age? **(***It is important that the development of pre-term babies is monitored by a paediatrician or neonatologist after discharge from the neonatal unit)*	66.4%	Within expected range	Did not meet

(Source: National Neonatal Audit Programme)

The results from the national neonatal audit programme show that the trust was in line with or better than the national average. Following the results of the audit an action plan was developed and posters displayed on the unit to inform parents of the results and what they were going to do to improve the results further.

Emergency readmission rates within two days of discharge

The tables below show the percentage of patients (by age group) who were readmitted following an emergency admission. The tables show the three specialties with the highest volume of readmissions and only those specialties where six or more readmissions recorded are shown in the table.

The data shows that from February 2018 to January 2019 there were no readmissions of under ones following an elective admission:

Emergency readmissions within two days of discharge following elective admission among the under 1 age group, by treatment specialty (February 2018 to January 2019)				
Specialty	**Bradford Teaching Hospital NHS Foundation Trust**			**England**
	Readmission rate	**Discharges (n)**	**Readmissions (n)**	**Readmission rate**
Plastic surgery	0.0%	15	0	0.5%
Paediatrics	0.0%	15	0	1.4%

For patients aged 1-17 years old, from February 2018 to January 2019, there were 10 readmissions following an elective admission with a readmission rate of 1.6% which was higher than the England average (0.7%). These occurred within the ear, nose and throat specialty:

Emergency readmissions within two days of discharge following elective admission among the 1-17 age group, by treatment specialty (February 2018 to January 2019)				
Specialty	**Bradford Teaching Hospital NHS Foundation Trust**			**England**
	Readmission rate	**Discharges (n)**	**Readmissions (n)**	**Readmission rate**
Ear, nose and throat	1.6%	620	10	0.7%

The data shows that from February 2018 to January 2019 there was a higher percentage of under ones readmitted following an emergency admission compared to the England average for paediatrics:

Emergency readmissions within two days of discharge following emergency admission among the under 1 age group, by treatment specialty (February 2018 to January 2019)				
Specialty	**Bradford Teaching Hospital NHS Foundation Trust**			**England**
	Readmission rate	**Discharges (n)**	**Readmissions (n)**	**Readmission rate**
Paediatrics	4.8%	2,805	135	3.6%

For patients aged 1-17 years old, there were a higher percentage of patients readmitted following an emergency admission compared to the England average for three specialties: paediatrics, general surgery and plastic surgery:

Emergency readmissions within two days of discharge following emergency admission among the 1-17 age group, by treatment specialty (February 2018 to January 2019)

Specialty	Bradford Teaching Hospital NHS Foundation Trust			England
	Readmission rate	Discharges (n)	Readmissions (n)	Readmission rate
Paediatrics	4.6%	7,030	320	2.9%
General surgery	8.2%	490	40	4.4%
Plastic surgery	3.3%	460	15	1.9%

(Source: Hospital Episode Statistics)

Rate of multiple emergency admissions within 12 months among children and young people for asthma, epilepsy and diabetes

From February 2018 to January 2019, the trust (15.4%) performed similar to the England average (15.9%) for the percentage of patients under the age of one who had multiple readmissions for asthma (1-17 year olds).

For diabetes, the proportions have been suppressed to protect patient confidentiality due to low numbers. The trust (33.3%) performed slightly worse than the England average (28.9%) for epilepsy (1-17 year olds):

Rate of multiple (two or more) emergency admissions within 12 months among children and young people for asthma, epilepsy and diabetes (February 2018 to January 2019)

Long term condition	Bradford Teaching Hospital NHS Foundation Trust			England
	Multiple admission rate	At least one admission (n)	Two or more admissions (n)	Multiple admission rate
Asthma				
Under 1	-	-	-	9.7%
1-17	15.4%	260	40	15.9%
Diabetes				
Under 1	0.0%	-	0	17.6%
1-17	*	35	*	12.8%
Epilepsy				
Under 1	*	*	*	33.7%
1-17	33.3%	60	20	28.9%

Notes: ' -' means there were no admissions in this category. To protect patient confidentiality, figures between 1 and 7 and their associated proportions have been suppressed and replaced with "" (an asterisk). Where it was possible to identify numbers from the total due to a single suppressed number in a row or column, an additional number (generally the next smallest) has also been suppressed.*
Figures greater than 7 are rounded to the nearest 5 and the calculated percentage from the rounded figures may be suppressed if patient confidentiality could be breached.

(Source: Hospital Episode Statistics)

Other CQC Survey Data

CQC Children and Young People's Survey 2016 Data

The trust performed similar to other trusts for all questions relating to effectiveness in the CQC Children and Young People's Survey 2016.

CQC Children's Survey questions, effective domain, Bradford Teaching Hospitals NHS Foundation Trust

Question Number	Question	Age group	Trust score	RAG
21	Did you feel that staff looking after your child knew how to care for their individual or special needs?	0-15 adults	8.2	About the same
9	Did staff play with your child at all while they were in hospital?	0-7 adults	6.3	About the same
19	Did different staff give you conflicting information?	0-7 adults	7.6	About the same
33	During any operations or procedures, did staff play with your child or do anything to distract them?	0-15 adults	6.8	About the same
54	Did hospital staff play with you or do any activities with you while you were in hospital?	8-11 CYP	4.2	About the same

(Source: CQC Children and Young People's Survey 2016, RCPCH)

Competent staff

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

Managers gave all new staff a full induction tailored to their role before they started work. The practice development nurses supported the learning and development needs of staff. The practice development nurse on the children's unit had produced a new starter's pack and met with new starters monthly. The pack contained competencies to complete. New starters were assigned a team leader, preceptor and associate preceptor. New starters attended monthly stabilisation sessions to introduce them to caring for a deteriorating child.

We spoke with a newly qualified nurse on the neonatal unit. They had received a good induction, which included two weeks of working supernumerary and four weeks of supervised practice. They had a competency package to complete. The practice development nurse had completed a lot of their training and the team were very supportive.

Simulation sessions were carried out on the children's unit and the neonatal unit, to increase staff's knowledge and skills.

Competencies for staff to complete included nasogastric tubes, paediatric advanced warning scores (PAWS), medication, enteral feeding, suction, oxygen, vapotherm, tracheostomy, catheter, central venous access devices and blood competency.

The diabetes team provided staff with six, twenty minute teaching sessions to increase their skills and knowledge in caring for children and young people with diabetes.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of children, young people and their families. Fifty five percent of staff on the children's unit had completed the European Paediatric Life Support (EPLS) training. There was always a staff member trained in EPLS on every shift.

Appraisal rates

Managers supported staff to develop through yearly, constructive appraisals of their work.

Whilst the data below shows the trust target not being met, we asked for updated information whilst on inspection, which showed that at September 2019, appraisal completion rate for the children's business unit was 95.8%.

From August 2018 to July 2019, 84.2% of staff within children's services at the trust received an appraisal compared to a trust target of 95% by December each year.

Trust level

Staff group	August 2018 to July 2019				
	Staff who received an appraisal	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Healthcare Scientists	1	1	100.0%	95%	Yes
Additional Clinical Services	43	50	86.0%	95%	No
Administrative and Clerical	43	50	86.0%	95%	No
Nursing and Midwifery Registered	135	158	85.4%	95%	No
Allied Health Professionals	10	13	76.9%	95%	No
Medical and Dental	3	4	75.0%	95%	No
Add Prof Scientific and Technic	4	6	66.7%	95%	No
Estates and Ancillary	1	3	33.3%	95%	No

Bradford Royal Infirmary

Staff group	August 2018 to July 2019				
	Staff who received an appraisal	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Healthcare Scientists	1	1	100.0%	95%	Yes
Administrative and Clerical	41	48	85.4%	95%	No
Nursing and Midwifery Registered	128	150	85.3%	95%	No
Additional Clinical Services	32	39	82.1%	95%	No
Medical and Dental	3	4	75.0%	95%	No
Add Prof Scientific and Technic	4	6	66.7%	95%	No
Estates and Ancillary	1	3	33.3%	95%	No

St Luke's Hospital

Staff group	August 2018 to July 2019				
	Staff who received an appraisal	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Additional Clinical Services	11	11	100.0%	95%	Yes
Administrative and Clerical	2	2	100.0%	95%	Yes
Nursing and Midwifery Registered	7	8	87.5%	95%	No
Allied Health Professionals	10	13	76.9%	95%	No

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit children, young people and their families. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss children and young people and improve their care. Safety huddles included nursing staff and medical staff, the safeguarding nurse for the trust also attended.

A twice weekly multidisciplinary ward round was held on the neonatal unit.

Staff referred children and young people for mental health assessments when they showed signs of mental ill health, depression. Staff on the children's unit told us the child and adolescent mental health service (CAMHS) visited the ward and they had good links with the team.

Some specialities held joint clinics with adult practitioners when children were transitioning to adult care. There were transition nurses employed who coordinated their care.

Within the children and young people's service, play specialists were employed to provide support to children and their families. The children's unit benefitted from a school room and two teachers.

The service held joint meetings with surgeons and anaesthetists.

Monthly multidisciplinary stabilisation meetings were held, which included external agencies such as the local paediatric intensive care unit (PICU) and the children's regional transport service.

CQC Children and Young People's Survey 2016 – Q23

In the CQC Children and Young People's Survey 2016 the trust scored 8.5 out of ten for the question 'Did the members of staff caring for your child work well together?' This was about the same as other trusts.

(Source: CQC Children and Young People's Survey 2016, RCPCH)

Seven-day services

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

Consultants led daily ward rounds on all wards, including weekends.

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

The ambulatory care experience (ACE) service provided care from 8.30am to 8.30pm, seven days a week, 365 days a year. Children and young people under the care of the ACE team had 24 hour access to the clinical decision area within the children's unit.

The children's community nursing team worked from 8am to 8pm, Monday to Friday and 8am to 6pm at the weekends.

Children's outpatients were open 8.30am to 5pm, Monday to Friday, there were no clinics at evenings or weekends.

The play staff worked Monday to Friday, 8am until 7pm. There were no play staff available to support children and young people at the weekend, although children and young people could still access the play facilities.

Health promotion

Staff gave children, young people and their families practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards/units.

Staff assessed each child and young person's health when admitted and provided support for any individual needs to live a healthier lifestyle.

The outpatients department had several health promotion displays. We saw a display related to sugar and another about bullying.

Information was provided around a number of health conditions.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported children, young people and their families to make informed decisions about their care and treatment. They knew how to support children, young people and their families who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a child or young person had the capacity to make decisions about their care. Staff made sure children, young people and their families consented to treatment based on all the information available. Staff we spoke with told us the voice of the child was included in their mental capacity training.

When children, young people or their families could not give consent, staff made decisions in their best interest, taking into account their wishes, culture and traditions. Staff we spoke with told us a referral was made to the safeguarding team if they had concerns around a parents mental capacity.

Staff clearly recorded consent in the children and young people's records.

Staff understood Gillick Competence and supported children who wished to make decisions about their treatment. Staff we spoke with told us the consultants took the lead on assessing Gillick competency.

Mental Capacity Act training completion

Nursing and medical staff received and kept up to date with training in the Mental Capacity Act.

Trust level

The trust set a target of 85% for completion of Mental Capacity Act (MCA) training.

A breakdown of compliance for MCA training courses from April 2018 to March 2019 at trust level

for qualified nursing staff in children's services is shown below:

Training module name	April 2018 to March 2019				
	Eligible staff	Staff trained	Completion rate	Trust target	Met (Yes/No)
Mental Capacity Act Level 1	145	145	100.0%	85%	Yes
Mental Capacity Act Level 2	146	142	97.3%	85%	Yes

In children's services the target was met for both the MCA training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 at trust level for medical staff in children's services is shown below:

Training module name	April 2018 to March 2019				
	Eligible staff	Staff trained	Completion rate	Trust target	Met (Yes/No)
Mental Capacity Act Level 2	1	1	100.0%	85%	Yes
Mental Capacity Act Level 1	27	27	100.0%	85%	Yes

In children's services the target was met for both the MCA training modules for which medical staff were eligible.

Bradford Royal Infirmary

The trust set a target of 85% for completion of Mental Capacity Act (MCA) training.

A breakdown of compliance for MCA training courses from April 2018 to March 2019 at Bradford Royal Infirmary for qualified nursing staff in children's services is shown below:

Training module name	April 2018 to March 2019				
	Eligible staff	Staff trained	Completion rate	Trust target	Met (Yes/No)
Mental Capacity Act Level 1	136	136	100.0%	85%	Yes
Mental Capacity Act Level 2	137	133	97.1%	85%	Yes

In children's services the target was met for both the MCA training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 at trust level for medical staff in children's services is shown below:

Training module name	April 2018 to March 2019				
	Eligible staff	Staff trained	Completion rate	Trust target	Met (Yes/No)
Mental Capacity Act Level 2	1	1	100.0%	85%	Yes
Mental Capacity Act Level 1	27	27	100.0%	85%	Yes

In children's services the target was met for both the MCA training modules for which medical staff were eligible.

St Luke's Hospital

The trust set a target of 85% for completion of Mental Capacity Act (MCA) training.

A breakdown of compliance for MCA/DOLS training courses from April 2018 to March 2019 at St Luke's Hospital for qualified nursing staff in children's services is shown below:

Training module name	April 2018 to March 2019				
	Eligible staff	Staff trained	Completion rate	Trust target	Met (Yes/No)
Mental Capacity Act Level 2	9	9	100.0%	85%	Yes
Mental Capacity Act Level 1	9	9	100.0%	85%	Yes

In children's services the target was met for both the MCA training modules for which qualified nursing staff were eligible.

There was no medical staff MCA training compliance data for children's services at St Luke's Hospital supplied by the trust.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Is the service caring?

Compassionate care

Staff treated children, young people and their families with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for children, young people and their families. Staff took time to interact with children, young people and their families in a respectful and considerate way. We observed staff speaking to people in a caring manner.

Children, young people and their families said most staff treated them well and with kindness.

Staff followed policy to keep care and treatment confidential.

Staff understood and respected the individual needs of each child and young person and showed understanding and a non-judgmental attitude when caring for or discussing those with mental health needs.

Staff understood and respected the personal, cultural, social and religious needs of children, young people and their families and how they may relate to care needs.

Parents on the neonatal unit were given a welcome pack which included a water bottle, baby blankets, tokens for the parent lockers and reading books.

CQC Children and Young People's Survey 2016

The trust performed similar to other trusts for all questions relating to compassionate care in the CQC Children and Young People's Survey 2016.

CQC Children and Young People's Survey 2016 questions, compassionate care, Bradford Teaching Hospitals NHS Foundation Trust

Question	Question	Age	Trust	RAG

Number		group	score	
10	Did new members of staff treating your child introduce themselves?	0-7 adults	8.3	About the same as other trusts
14	Did you have confidence and trust in the members of staff treating your child?	0-15 adults	8.6	About the same as other trusts
22	Were members of staff available when your child needed attention?	0-15 adults	8.1	About the same as other trusts
42	Do you feel that the people looking after your child were friendly?	0-7 adults	8.7	About the same as other trusts
43	Do you feel that your child was well looked after by the hospital staff?	0-7 adults	8.6	About the same as other trusts
44	Do you feel that you (the parent/carer) were well looked after by hospital staff?	0-15 adults	7.6	About the same as other trusts
58	Was it quiet enough for you to sleep when needed in the hospital?	8-15 CYP	5.6	About the same as other trusts
64	If you had any worries, did a member of staff talk with you about them?	8-15 CYP	8.8	About the same as other trusts
74	Do you feel that the people looking after you were friendly?	8-15 CYP	9.4	About the same as other trusts
75	Overall, how well do you think you were looked after in hospital?	8-15 CYP	8.7	About the same as other trusts

(Source: CQC Children and Young People's Survey 2016, RCPCH)

Emotional support

Staff provided emotional support to children, young people and their families to minimise their distress. They understood children and young people's personal, cultural and religious needs.

Staff gave children, young people and their families help, emotional support and advice when they needed it.

Staff supported children, young people and their families who became distressed in an open environment, and helped them maintain their privacy and dignity.

Staff understood the emotional and social impact that a child or young person's care, treatment or condition had on their, and their families, wellbeing.

Play specialists were available to provide support to those children and young people undergoing procedures, to help minimise their distress.

The neonatal unit had just appointed two third year psychology students who provided emotional support to parents on the unit.

CQC Children and Young People's Survey 2016

The trust performed about the same as other trusts three questions relating to emotional support in the CQC Children and Young People's Survey 2016. The table below show the trust's performance for the questions which were asked to both adults and children:

CQC Children and Young People's Survey 2016 questions, emotional support, Bradford Teaching Hospitals NHS Foundation Trust

Question Number	Question	Age group	Trust score	RAG
7	Was your child given enough privacy when receiving care and treatment?	0-7 adults	8.3	Worse than other trusts
29	If your child felt pain while they were at the hospital, do you think staff did everything they could to help them?	0-15 adults	8.3	About the same as other trusts
45	Were you treated with dignity and respect by the people looking after your child?	0-7 adults	8.8	About the same as other trusts
65	Were you given enough privacy when you were receiving care and treatment?	8-15 CYP	9.5	Better than other trusts
67	If you felt pain while you were at the hospital, do you think staff did everything they could to help you?	8-15 CYP	8.7	About the same as other trusts

(Source: CQC Children and Young People's Survey 2016, RCPCH)

Understanding and involvement of patients and those close to them

Staff supported and involved children, young people and their families to understand their condition and make decisions about their care and treatment. They ensured a family centred approach.

Staff made sure children, young people and their families understood their care and treatment. However, a couple of the mothers we spoke to on the transitional care ward told us they had not had it explained to them that they were on the transitional care ward and were not aware their baby was being cared for by a neonatal nurse, until they had raised issues with the midwifery team.

Staff talked with children, young people and their families in a way they could understand, using communication aids where necessary.

Children, young people and their families could give feedback on the service and their treatment and staff supported them to do this. The children's unit used 'pants and tops' a feedback tool, for children to give feedback.

Staff supported children, young people and their families to make informed decisions about their care.

Children, young people and their families gave positive feedback about the service.

Parents on the neonatal unit were encouraged to attend the ward rounds.

CQC Children and Young People's Survey 2016

The trust performed about the same as other trusts for better than other trusts for 17 questions relating to understanding and involvement of patients and those close to them in the CQC Children and Young People's Survey 2016. The trust performed better than for the following questions:

- Did the hospital staff answer your questions?
- Were you involved in decisions about your care and treatment?
- Before the operations or procedures, did hospital staff explain to you what would be done?

CQC Children and Young People's Survey 2016 questions, understanding and involvement of patients, Bradford Teaching Hospitals NHS Foundation Trust

Question Number	Question	Age group	Trust score	RAG
11	Did members of staff treating your child give you information about their care and treatment in a way that you could understand?	0-15 adults	8.8	About the same as other trusts
12	Did members of staff treating your child communicate with them in a way that your child could understand?	0-7 adults	7.6	About the same as other trusts
13	Did a member of staff agree a plan for your child's care with you?	0-15 adults	8.8	About the same as other trusts
15	Did staff involve you in decisions about your child's care and treatment?	0-15 adults	8.0	About the same as other trusts
16	Were you given enough information to be involved in decisions about your child's care and treatment?	0-15 adults	8.2	About the same as other trusts
17	Did hospital staff keep you informed about what was happening whilst your child was in hospital?	0-15 adults	8.2	About the same as other trusts
18	Were you able to ask staff any questions you had about your child's care?	0-15 adults	8.6	About the same as other trusts
31	Before your child had any operations or procedures did a member of staff explain to you what would be done?	0-15 adults	9.5	About the same as other trusts
32	Before the operations or procedures, did a member of staff answer your questions in a way you could understand?	0-15 adults	9.4	About the same as other trusts
34	Afterwards, did staff explain to you how the operations or procedures had gone?	0-15 adults	8.7	About the same as other trusts
39	When you left hospital, did you know what was going to happen next with your child's care?	0-15 adults	8.1	About the same as other trusts
41	Do you feel that the people looking after your child listened to you?	0-7 adults	8.5	About the same as other trusts
59	Did hospital staff talk with you about how they were going to care for you?	8-15 CYP	9.1	About the same as other trusts
60	When the hospital staff spoke with you, did you understand what they said?	8-15 CYP	8.6	About the same as other trusts

61	Did you feel able to ask staff questions?	8-15 CYP	9.6	About the same as other trusts
62	Did the hospital staff answer your questions?	8-15 CYP	9.9	Better than other trusts
63	Were you involved in decisions about your care and treatment?	8-15 CYP	7.4	Better than other trusts
66	If you wanted, were you able to talk to a doctor or nurse without your parent or carer being there?	12-15 CYP	No Score	No Score
69	Before the operations or procedures, did hospital staff explain to you what would be done?	8-15 CYP	10.0	Better than other trusts
70	Afterwards, did staff explain to you how the operations or procedures had gone?	8-15 CYP	8.4	About the same as other trusts
72	When you left hospital, did you know what was going to happen next with your care?	8-15 CYP	8.2	About the same as other trusts

(Source: CQC Children and Young People's Survey 2016, RCPCH)

Is the service responsive?

Service delivery to meet the needs of local people

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

Managers planned and organised services so they met the changing needs of the local population. Focus groups were held with different sets of parents to help inform service leads in their development of the service.

The head of nursing linked in to the strategic children's board, the neonatal network and the paediatric critical care network.

The service was working closely with clinical commissioning groups (CCGs) and other providers to develop pathways for autism referrals and improve the looked after children (LAC) and adoption service. Services for autism and LAC and adoption were not meeting national guidance. This had been identified on the risk register.

Facilities and premises were appropriate for the services being delivered. The new children's unit (wards 30 and 32) opened in 2017 and children and families had been involved with the design of the new unit. There was a large play room and a separate adolescent room. These rooms were open 24 hours a day for children and young people to access.

Staff could access emergency mental health support 24 hours a day 7 days a week for children and young people with mental health problems and learning disabilities. The staff on the children's unit had been working closely with the parent of a child with autism and mental health needs to try to provide a suitable environment for those children with additional needs.

The service had systems to care for children and young people in need of additional support, specialist intervention, and planning for transition to adult services. A sensory room and physiotherapy room were situated on the children's unit. However, at the time of our inspection, this

was not in use as there had been a water leak in the room. Two specialist transition nurses were employed to support those children with complex needs who were moving to adult health services. Service leads acknowledged there was more work to do around transition, they had recently joined a transition collaborative and were starting work with the haemoglobinopathy services to improve the transition pathway for young people. The aim was to roll out the findings to other specialities.

Managers monitored and took action to minimise missed appointments.

Managers ensured that children, young people and their families who did not attend appointments were contacted.

The neonatal unit used a video link system, 'baby view', to allow staff to send close up images directly to parents or relatives around the world.

Young people from the age of 14 years were given the choice of where they wanted to be nursed, either on the children's unit or an adult ward. The children's services were aware of any young person that was nursed on an adult ward and provided support.

Both the children's unit and the neonatal unit had parent rooms, where parents could go to sit and make themselves a drink.

The children's unit had beds available for parents to sleep at the side of their children. The neonatal unit had two bedrooms on the unit for parents and two bedrooms in another location. Priority was given for those parents who had very sick babies, those who were rooming in (prior to discharge) and those parents who lived out of area. National guidance suggests there should be a bedroom available for each intensive care cot, staff told us there were plans in place for an extension to increase the number of parent bedrooms available.

The children's unit and the neonatal unit had quiet rooms, which could be used for breaking bad news or to give some privacy when needed.

CQC Children and Young People's Survey 2016

The trust performed about the same as other trusts for better than other trusts for 16 questions relating to responsiveness in the CQC Children and Young People's Survey 2016. The trust performed better than and worse than for the following questions:

- Better than other trusts for one question: Did a member of staff give you advice on how to look after yourself after you went home?
- Worse than other trusts for no questions

CQC Children and Young People's Survey 2016 questions, responsive domain, Bradford Teaching Hospitals NHS Foundation Trust

Question Number	Question	Age group	Trust score	RAG
4	For most of their stay in hospital what type of ward did your child stay on?	0-15 adults	9.7	About the same as other trusts
5	Did the ward where your child stayed have appropriate equipment or adaptations for your child's physical or medical needs?	0-15 adults	8.5	About the same as other trusts
25	Did you have access to hot drinks facilities in the hospital?	0-15 adults	8.4	About the same as other trusts
26	Were you able to prepare food in the hospital if you wanted to?	0-15 adults	3.7	About the same as other trusts

28	How would you rate the facilities for parents or carers staying overnight?	0-15 adults	7.1	About the same as other trusts
55	Was the ward suitable for someone of your age?	12-15 CYP	7.5	About the same as other trusts
8	Were there enough things for your child to do in the hospital?	0-7 adults	7.1	About the same as other trusts
24	Did your child like the hospital food provided?	0-7 adults	5.1	About the same as other trusts
37	Did a staff member give you advice about caring for your child after you went home?	0-15 adults	8.3	About the same as other trusts
38	Did a member of staff tell you who to talk to if you were worried about your child when you got home?	0-7 adults	8.5	About the same as other trusts
40	Were you given any written information (such as leaflets) about your child's condition or treatment to take home with you?	0-15 adults	7.6	About the same as other trusts
56	Were there enough things for you to do in the hospital?	8-15 CYP	7.0	About the same as other trusts
57	Did you like the hospital food?	8-15 CYP	5.7	About the same as other trusts
71	Did a member of staff tell you who to talk to if you were worried about anything when you got home?	8-15 CYP	8.4	About the same as other trusts
73	Did a member of staff give you advice on how to look after yourself after you went home?	8-15 CYP	9.2	Better than other trusts
2	Did the hospital give you a choice of admission dates?	0-7 adults	2.8	About the same as other trusts
3	Did the hospital change your child's admission date at all?	0-7 adults	9.0	About the same as other trusts

(Source: CQC Children and Young People's Survey 2016, RCPCH)

Meeting people's individual needs

The service was inclusive and took account of children, young people and their families' individual needs and preferences. Staff made reasonable adjustments to help children, young people and their families access services. They coordinated care with other services and providers.

Staff made sure children and young people living with mental health problems, learning disabilities and long term conditions received the necessary care to meet all their needs. In the adolescent room on the children's ward there was a poster displayed informing young people about services they could access which could provide support with emotional distress.

Wards were designed to meet the needs of children, young people and their families. The children's ward had an assisted bathroom, with a hoist and a changing area. All areas were wheelchair accessible.

The play staff had attended an autism reality experience. The autism reality experience gives people an experience of the sensory processing difficulties faced by people on the autism spectrum. Play staff we spoke with told us it had increased their knowledge as to how they could support those patients with autism.

Staff on ward two told us they would work with the families of any children with special needs, to better understand their needs. They offered a side room to patients with special needs and tried to ensure they were first on the theatre list. Children carried a special needs passport, to inform staff of their likes and dislikes.

Managers made sure staff, children, young people and their families could get help from interpreters or signers when needed.

Children going for surgery or an MRI could drive themselves to the department in a mini car, this helped to relieve some of their anxieties.

The children's service had several clinical nurse specialists who provided support to families. Specialist nurses included a respiratory nurse, epilepsy, diabetes, continence, gastroenterology, rheumatology and transition nurses.

The service employed a paediatric palliative care nurse and two family support workers to provide support to those families with children requiring palliative care, with the aim of trying to keep them out of hospital.

The lead nurse for the child development centre co-ordinated care for children with complex needs. They were able to make links between the community children's nurses, clinical nurse specialist and the inpatient wards. They also worked closely with social care and education.

The service was not meeting the accessible information standard. The standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents with a disability, impairment or sensory loss. Staff we spoke with told us they did not routinely ask parents about any disability, impairment or sensory loss they may have, and this was not recorded or flagged so that services could meet those needs.

Access and flow

People could access services when they needed them. However, waiting times from referral to treatment were not always in line with national standards.

Managers and staff worked to make sure children and young people did not stay longer than they needed to. The clinical decisions area (ward 32) took referrals from midwives, GPs, the emergency department and self-referrals from patients with direct access. Any children or young people that were expected to stay longer than 24 hours were transferred to the children's ward (ward 30).

The ACE team took referrals from the emergency department, GP's and the clinical decisions area. The aim of the service was to see children and young people at home to prevent admission to hospital and promote early discharge. The team had care pathways for croup, gastroenteritis and wheeze. They were launching a jaundice pathway the week following our inspection and the following month they were launching a bronchiolitis pathway. The ACE nurses phoned the family within two hours of referral and made a decision to visit based on the child's symptoms. Visits were completed as and when needed, there was no restriction on the number of visits that could be undertaken.

The children's community nursing team received referrals from any healthcare professional. They provided community nursing and continuing care. Staff we spoke with told us they were looking at developing referral criteria. All patients were seen within a couple of days of referral.

Ward two was a day care ward that was open from 7.30am to 8pm. Any children needing to stay overnight were transferred to the inpatient ward.

When children and young people had their operations cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance. There had been seven cancelled operations due to non-clinical reasons between September 2018 and September 2019. One cancelled operation was not rebooked within 28 days due to the complexity of the patient and availability of the surgeon from another trust.

Managers and staff worked to make sure that they started discharge planning as early as possible. On the neonatal unit, discharge planning started as soon as the baby was moved from a resuscitaire in to a cot.

The children's service were undertaking a quality improvement project with the aim of reducing the length of stay for children and young people with complex health needs, by introducing a pathway encouraging early referral to the children's community nursing team and early discharge planning. The plan was for the pathway to be introduced by January 2020.

A Getting It Right First Time (GIRFT) review of paediatric surgical services had taken place in November 2018. This had identified some areas for action, including reviewing the provision of paediatric surgical services, particularly around acute/ non-elective care and appropriate surgical support for the neonatal unit. The service had produced an action plan following this review.

In the children's outpatient department at St Luke's hospital we saw signs displayed informing parents of any delays in clinic, we also heard staff making an announcement to the waiting room about the delays, to keep families informed. Families we spoke with in the outpatients department told us they had never had long waits in the department.

The NHS standard for referral to treatment times is that at least 92% of patients should have a referral to treatment time of less than 18 weeks. The RTT performance for the service had been variable over the last 12 months. From September 2018 to December 2018, the children's services had been below the 92% standard, then from December 2018 to July 2019 they had been above the 92% standard. From July 2019, the RTT performance had declined and in September 2019 was around 89%. Data provided by the trust showed that in October 2019 the RTT was 89.6% overall, the lowest RTT's were 72.8% for community paediatrics, 75.5% for paediatric clinical immunology and allergy and 79.3% for paediatric urology. Paediatric neurology was 90% and 11 other specialities were above 92%. The average wait for an appointment was 20 weeks.

The service had ongoing concerns related to vacancies, maternity leave and demand for services. A business case had been written for more consultant staffing and the service leads were looking at alternative options to cover inpatient and outpatient workload, including the expansion of the advanced nurse practitioner (ANP) team, appointment of a GP with special interest and development of additional clinical nurse specialist roles. The waiting list size was around 1425 patients. Every referral was triaged by a consultant to ensure those most in need were prioritised. The service had developed an outpatients transformation plan, with the aim to modernise outpatient services by providing alternative delivery models, with the ultimate objective or reducing follow up appointments by 10% by October 2020.

Increasing demands on the child development service and community paediatrics meant the service was not meeting National Institute for Health and Care Excellence (NICE) guidance of patients having an autism assessment within three months of referral. There was a large waiting list and the longest wait was 146 weeks (over two and a half years). There was an ongoing piece of work led by the clinical commissioning group (CCG) and including other providers. A new pathway had been developed, which service leads told us meant the process for assessment would take six weeks rather than 12 months, once the process had commenced. We spoke with staff in the child development centre and they told us they signposted families to services that could provide support until they received their assessment.

Service leads had identified concerns around the epilepsy service provided, as it was not meeting the NICE quality standards. Due to capacity problems some children with seizures were triaged and seen by a general paediatrician rather than a paediatrician who led on epilepsy. There was only one paediatric epilepsy nurse specialist and there was no agreed transition service for epilepsy. An advert had been placed for a new consultant with an interest in epilepsy and a business case put forward for an increase in epilepsy nurse specialists.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Summary of complaints

Children, young people and their families knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them. Staff we spoke with told us they would try to deal with complaints at ward and department level but gave parents information on how to make a formal complaint if this was required.

Managers investigated complaints and identified themes. Staff we spoke with told us they received a minimal amount of complaints.

Trust level

From August 2018 to July 2019 the trust received 16 complaints in relation to children's services at the trust (3.1% of total complaints received by the trust). The trust took an average of 40.9 working days to investigate and close complaints. Trust policy was to provide a written response to complainants following an investigation into the issues raised within either 30 or 60 working days, depending on the complexity of the complaint. In some circumstances where complaints were more complex, different timescales were agreed with the complainant to respond to their concerns, within a maximum period of six months.A breakdown of complaints by type is shown below:

Type of complaint	Number of complaints	Percentage of total
Paediatric Group	11	68.8%
Appointments including delays and cancellations	3	18.8%
Psychiatry Group	1	6.3%

Obstetrics and Gynaecology	1	6.3%
Total	**16**	**100.0%**

Of these 16 complaints, the following seven complaints related to Bradford Royal Infirmary:

Type of complaint	Number of complaints	Percentage of total
Paediatric Group	6	85.7%
Appointments including delays and cancellations	1	14.3%
Total	**7**	**100.0%**

Of these 16 complaints, the following nine complaints related to St Luke's Hospital:

Type of complaint	Number of complaints	Percentage of total
Paediatric Group	5	55.6%
Appointments including delays and cancellations	2	22.2%
Psychiatry Group	1	11.1%
Obstetrics and Gynaecology	1	11.1%
Total	**9**	**100.0%**

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Number of compliments made to the trust

Managers shared feedback from complaints with staff and learning was used to improve the service.

From August 2018 to July 2019 there were 13 compliments about children's services at the trust. A breakdown of compliments by site is below:

Site	Number of compliments	Percentage of total
Bradford Royal Infirmary	12	92.3%
St Luke's Hospital	1	7.7%
Total	**13**	**100.0%**

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Is the service well-led?

Leadership

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

The trust had established a clinical business unit model with operational managers and clinical leaders working in partnership to deliver improved outcomes for patients and improved operational and financial performance. The children's clinical business unit was led by a head of nursing for paediatrics, a clinical director and a general manager. The head of nursing had been in post since 2015, the clinical director was appointed in April 2019 and the general manager had joined the team in August 2019.

Leaders understood the challenges in the service and had plans in place to address these.

The medical director of the trust was the designated children's lead at trust board level and the chief nurse was the children's nurse lead.

Staff we spoke with spoke positively about leaders at all levels within the children's clinical business unit. Leaders were described as visible, open and supportive.

All consultants had job plans, the clinical director met with the consultants and discussed them. Half of the consultants job plans had been updated and the other half were due to be updated following their discussions.

Vision and strategy

The service had a vision for what it wanted to achieve and were developing a strategy to turn it into action.

Service leads had a vision for the service to provide high quality specialist care closer to home.

Service leads told us they were working on development of a five year strategy. They had developed a position statement of where the service currently was and had assessed the strengths, weaknesses, opportunities and threats. The outputs from this work were to be used to develop the short and long term plans for the service. Plans were to develop the strategy with engagement from staff within the clinical business unit and external providers.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

All staff we spoke with appeared positive and felt proud to work for the service. Many of the staff we spoke with on the children's unit told us that the service had improved since moving to the new environment. They felt the service had improved for staff as well as patients and their families.

All staff we spoke with told us they felt safe to raise concerns, they felt listened to and said they knew action would be taken where it could be.

There was a patient centred culture and the service was involved in a number of quality improvement programmes to try to improve services for children and their families.

A lone worker policy was in place for those staff working in the community and staff carried lone worker devices to try to protect their safety.

Governance

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

The service had a consultant paediatrician who was the clinical governance lead.

The service held regular governance meetings. Monthly children's core group governance meetings were held. Terms of reference had been developed for these meetings. Standing agenda items looked at safety, quality, patient experience and external reports. Any items requiring escalation from

these meetings were escalated to the planned care group governance meetings, which in turn were fed up to the patient safety subcommittee and the board. We reviewed minutes from the governance meetings and saw action logs were completed. There was evidence of review of the actions and updates documented.

There was a children and young people's board, which was a subcommittee of the trust quality and safety committee. The purpose of the board was to provide assurance to the trust quality and safety committee that safe and effective services were delivered to children and young people. A paediatric surgery and anaesthesia group reported in to the children and young people's board.

Following our inspection, we requested minutes from team meetings for each ward for the last three months. We did not receive these but received minutes from the community band six nurses meeting in July 2019. We also received minutes of ward 30/32 meeting from January 2019, minutes of a ward practice meeting from July 2019 and minutes from a consultant meeting in September 2019. A complex discharge collaborative meeting took place in November 2019. We were told that although meetings took place, they were not always minuted.

Although we did not see evidence of regular team meetings, we saw evidence that staff received feedback through weekly learning newsletters and staff we spoke with told us they received feedback via emails, newsletters, their private social media page and attending safety huddles.

Management of risk, issues and performance

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

Service leads clearly identified the risks to their service and could explain to us how they were addressing the risks. The service worked well with other organisations to try to reduce risks.

The children's clinical business unit held a risk register. At the time of our inspection, there were 26 recorded risks. The risk register contained evidence of existing control measures, mitigation, summaries of ongoing action and review dates.

Service leads identified their top risks as the paediatric epilepsy service, community paediatrics capacity and demand, referral to treatment times and the interface between paediatrics and the emergency department. We saw risk assessments had been completed for each of these risks, which documented the additional control measures required to reduce the risk and the timescales for completion.

Weekly risk meetings were held which looked at the incident reports for the week, NICE guidance, serious incidents, policies and duty of candour.

The service had quality improvement and audit plans for the year ahead.

Information management

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

A monthly scorecard was produced which allowed service leads to keep track of performance. The scorecard included quality performance indicators, workforce performance indicators, finance

performance indicators and operational performance indicators. Contained within the report were the 12 month trend, a description of the current performance and actions to sustain or improve the position.

Service performance measures were reported through a dashboard, which was discussed at the governance meeting. These results were displayed in the ward areas, so visitors could see how the service was performing.

There were arrangements in place for submitting data and notifications to external bodies.

Engagement

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

Children and young people were encouraged to share their views. On the children's wards, they used 'tops' and 'pants', a feedback tool for children to describe what they liked best about the service and what they liked least. These were displayed in the play room. The service also displayed what action had been taken as a result of feedback.

Parents and patients on ward two were asked for their feedback on what they liked about the ward and what they could improve. Posters were displayed which showed what they were doing to try to improve.

Questionnaires were sent to children and young people to gain their opinions on services. For example, a questionnaire was sent to patients attending the inflammatory bowel disease transition clinics in order to evaluate the service. A survey had been conducted for young people receiving care on adult wards.

The neonatal unit had parent feedback forms. They displayed 'you said, we did' information on the unit. We saw lots of positive feedback had been provided and responses to suggestions for improvement.

Service leads engaged well with staff. All staff we spoke with described the leaders as approachable. Staff received weekly newsletters.

Learning, continuous improvement and innovation

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

The ambulatory care experience (ACE) team won a health service journal (HSJ) award in 2018 for outstanding contribution. A grant had been given from Health Education England to train nurses in neighbouring trusts to deliver the package of care.

The ACE team were trialling an all in one telehealth device that would enable them to carry out on-demand examinations and diagnoses remotely.

Staff in children's services displayed a desire to learn and continually improve. There were several quality improvement projects that had been completed and there were plans for further quality improvement projects over the next year.

The neonatal unit used 'babyview', technology that meant parents could remotely see their baby in the neonatal unit.

Children’s services were working to improve the delivery of mental health care within the service. They had worked closely with the mother of a child with mental health needs, who had provided valuable insight in to how services could improve.

The service had a children’s and neonatal research team.

Outpatients

Facts and data about this service

The trust offers acute outpatient services at Bradford Royal Infirmary, Shipley Hospital and St Luke's Hospital. In addition, some outpatient services are provided at Delius special school. The table below shows the services provided at each site:

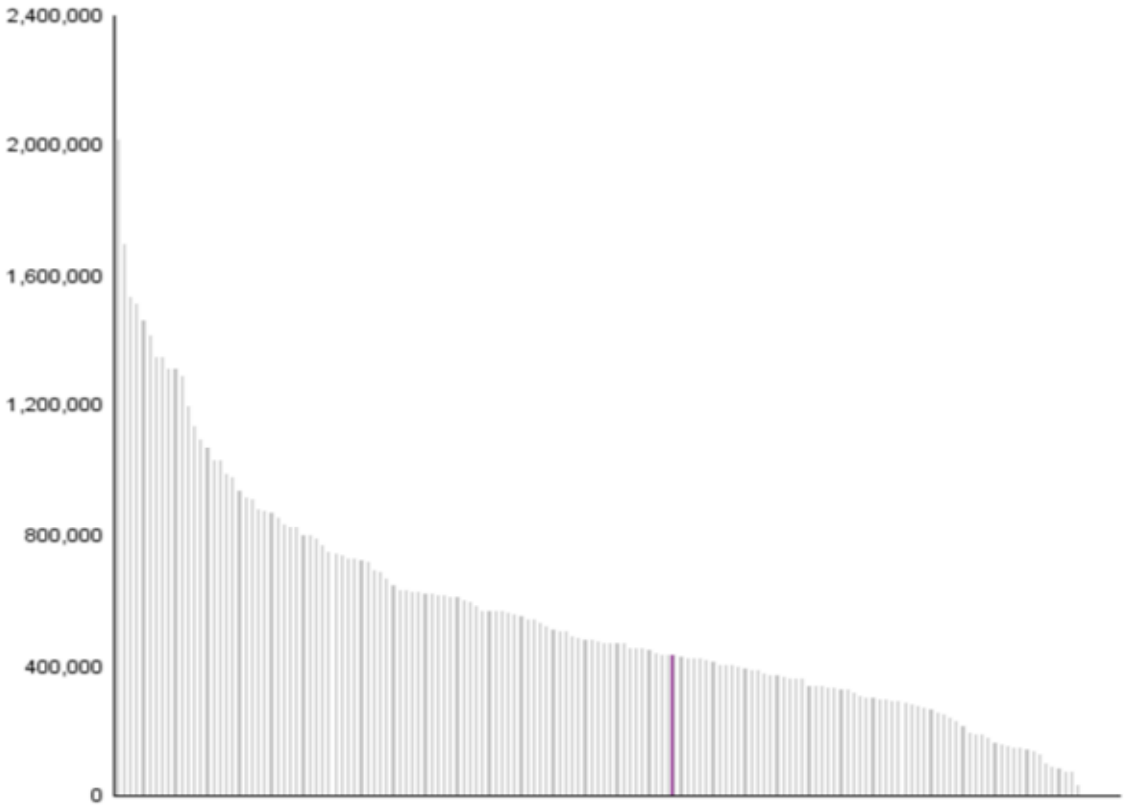
Site	Team	Services
Bradford Royal Infirmary	Diabetes & Endocrinology Unit	The department provides multidisciplinary outpatient services to adults with diabetes and endocrine disorders. The diabetes team provide a service for newly diagnosed patients and those with existing diabetes. It also offers an insulin pump service, renal diabetes support, a service for adolescent patients and a service for those with rare or atypical forms of diabetes and all patients with complex diabetic needs. The endocrinology team deal with a wide range of problems including pituitary dysfunction, adrenal disorders, thyroid disorders, reproductive disorders, calcium metabolism, osteoporosis and trans gender reassignment.
	Adult Outpatients	The adult outpatients facility is the route from primary care into secondary care outpatient consultation, follow up review, diagnostic testing and treatment. It is consultant led and supported by a multi-disciplinary team. All rooms are equipped with Electronic Patient Record (EPR) and PACS/Pathology IT facilities.
	Audiology	A head and neck outpatient area with HTML standard audiology booths based within the ear nose and throat (ENT) outpatients section. The consultant led service is supported by a multi-disciplinary team of nursing, allied health professionals (AHP) and clinical scientists. A child friendly play area is provided for our paediatric visitors and the decor is colourful and inviting.
	Bradford Macular Unit	The Macula Centre is for the people of Bradford and beyond, and it means that patients with suspected wet macular degeneration, will be seen and treated for this condition more quickly, improving the success of the treatment.
	ENT and Ophthalmology Outpatients	A head and neck outpatient area with both an ophthalmology suite and ENT outpatients section. It is a consultant led service and is supported by a multi-disciplinary team of nursing, AHP and clinical scientists. A child friendly play area is provided for paediatric visitors. This is the route from primary care into secondary care outpatient consultation, follow up review, diagnostic testing and treatment.
	Haematology & Oncology Clinics - Out Patients	This facility provides specialist clinics including: lymphoma, haemostasis, myeloid, myeloma and chronic lymphatic leukaemia, anaemia and haemoglobin clinics. The consultant led team is supported by an multidisciplinary team (MDT) consisting of specialist nurses, nursing, AHPs and clinical scientists.
	Trauma and Orthopaedic Outpatients	The trauma and orthopaedics outpatient area is co-located with the emergency department (ED), radiology and the plaster room to enable outpatient consultation, follow up review, fracture clinics, diagnostic testing and treatment. The service is consultant led, supported by a multi-disciplinary team.
	Plastics and	A dedicated plastics and trauma outpatient follow up and dressing

	Trauma Dressing Clinic	clinic, accepting patients directly from ED for treatment. The team provides an outreach response to support the ED team during patient consultations and trauma calls.
Shipley Hospital	Outpatients	Physiotherapy, colorectal, out patients and GP direct access X-ray services. This is an outreach location providing the opportunity to deliver care closer to home from this locality. The facility provides capacity for outpatient consultation, follow up review, diagnostic testing and treatment. It is consultant led and supported by a multi-disciplinary team.
St Luke's Hospital	Dermatology Outpatients	The dermatology service is a multi-disciplinary team delivering a wide range of specialist dermatological services predominantly within a dedicated outpatient setting. The service provides dermatology support to patients referred from primary care who have been assessed via a GP with special interest in dermatology for secondary care and also a skin cancer fast track and follow up service. Diagnostics, procedures and specialist treatments are provided within this location.
	HIV Service	"Trinity@StLukes is the Bradford clinic which treats and cares for HIV positive people. Around 420 patients attend the clinic and patients are seen following their HIV positive diagnosis in a variety of settings from GP surgeries, antenatal clinics, sexual health screening, and even home testing kits which are now available.
	Adult Outpatients	Services include a consultation, follow up review, diagnostic testing and treatment. It is consultant led and supported by a multi-disciplinary team. All rooms are equipped with EPR and PACS/Pathology IT facilities.
	Orthotics	The orthotics service is current based at St Luke's providing Orthotic devices to patients to provide pressure relief, correct or accommodate deformity and to improve function.
	Orthodontics	The orthodontic department in St Luke's is a dedicated area with a number of treatment chairs including one specifically designed to manage bariatric patients. The consultant led team is well supported by a team of dental nurses and technicians. The team provide outpatients consultations, advice and procedures.
	Pain Management Centre	The Bradford pain management team provide an experienced and specialised approach to the treatment of chronic pain. The team provide outpatient consultation, advice and treatment. They work closely with Musculoskeletal (MSK) service.
	Psychology	The psychology service provides consultation and treatment support to many specialties through a referral system for inpatient and outpatient care. This includes adult and child psychology providing a holistic experience for patients.

(Source: Routine Provider Information Request (RPIR) – P2. Sites tab)

Total number of first and follow up outpatient attendances compared to England

The trust had 432,092 first and follow up outpatient attendances from March 2018 to February 2019. The graph below represents how this compares to other trusts:



(Source: Hospital Episode Statistics - HES Outpatients)

Number of appointments by site

The following table shows the number of outpatient appointments by site, a total for the trust and the total for England, from March 2018 to February 2019:

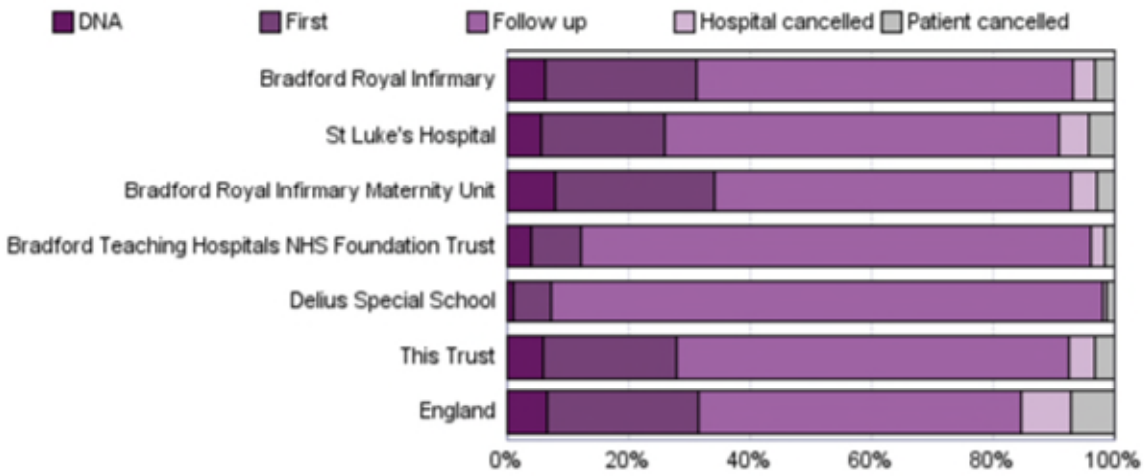
Site Name	Number of appointments
Bradford Royal Infirmary	213,657
St Luke's Hospital	197,781
Bradford Royal Infirmary Maternity Unit	48,515
Bradford Teaching Hospitals NHS Foundation Trust	22,011
Delius Special School	13,280
This Trust	499,616
England	109,324,322

(Source: Hospital Episode Statistics)

Type of appointments

The chart below shows the percentage breakdown of the type of outpatient appointments from March 2018 to February 2019. The percentage of these appointments by type can be found in the chart below:

Number of appointments at Bradford Teaching Hospitals NHS Foundation Trust from March 2018 to February 2019 by site and type of appointment



(Source: Hospital Episode Statistics)

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.
*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure most completed it.

Mandatory training completion rates

The trust set two different targets of 85% and 95% for completion of mandatory training. These targets were dependant on individual modules.

Trust level outpatient departments

A breakdown of compliance for mandatory training courses April 2018 to March 2019 at trust level for qualified nursing staff in outpatients is shown below:

Training module name	April 2018 to March 2019				
	Eligible staff	Staff trained	Completion rate	Trust target	Met (Yes/No)
Mental Capacity Act Level 2	14	14	100.0%	85%	Yes
Communication Improvement using the SBAR Technique General	14	14	100.0%	85%	Yes
Venous Thromboembolism - No Renewal	12	12	100.0%	85%	Yes
Mental Capacity Act Level 1	14	14	100.0%	85%	Yes
Corporate Induction	14	14	100.0%	85%	Yes
Infection Control - No Renewal	14	14	100.0%	85%	Yes
Introduction to Equality & Diversity General	14	14	100.0%	85%	Yes
Adult Basic Life Support - 1 Year	14	12	85.7%	85%	Yes
Diabetes Care and Safe Use of Insulin General	12	10	83.3%	85%	No

Information Governance - 1 Year	14	11	78.6%	95%	No
Safe Administration of Medicines - 2 Year	12	8	66.7%	85%	No
Infection Control - 1 Year	14	9	64.3%	85%	No
Conflict Resolution - 3 Years	14	8	57.1%	85%	No
Moving & Handling Medium/High Risk General	14	6	42.9%	85%	No

In outpatients, the 95% target was not met for the single applicable module and the 85% target was met for eight of the remaining 13 mandatory training modules for which qualified nursing staff were eligible.

The trust reported that there were no applicable medical staff at the trust for outpatients.

Bradford Royal Infirmary outpatient department

A breakdown of compliance for mandatory training courses April 2018 to March 2019 at Bradford Royal Infirmary for qualified nursing staff in outpatients is shown below:

Training module name	April 2018 to March 2019				
	Eligible staff	Staff trained	Completion rate	Trust target	Met (Yes/No)
Communication Improvement using the SBAR Technique General	6	6	100.0%	85%	Yes
Venous Thromboembolism - No Renewal	4	4	100.0%	85%	Yes
Mental Capacity Act Level 2	6	6	100.0%	85%	Yes
Mental Capacity Act Level 1	6	6	100.0%	85%	Yes
Introduction to Equality & Diversity General	6	6	100.0%	85%	Yes
Corporate Induction	6	6	100.0%	85%	Yes
Infection Control - No Renewal	6	6	100.0%	85%	Yes
Adult Basic Life Support - 1 Year	6	6	100.0%	85%	Yes
Diabetes Care and Safe Use of Insulin General	4	3	75.0%	85%	No
Conflict Resolution - 3 Years	6	4	66.7%	85%	No
Information Governance - 1 Year	6	4	66.7%	95%	No
Safe Administration of Medicines - 2 Year	4	2	50.0%	85%	No
Infection Control - 1 Year	6	3	50.0%	85%	No
Moving & Handling Medium/High Risk General	6	2	33.3%	85%	No

Note: Please interpret completion rates with care where small numbers of staff are involved.

Most nursing staff received and kept up-to-date with their mandatory training.

In outpatients, 82% of eligible staff received mandatory training. The 95% target was not met for the single applicable module and the 85% target was met for eight of the remaining 13 mandatory training modules for which qualified nursing staff were eligible.

The trust reported that there were no applicable medical staff at the trust for outpatients.

The mandatory training was comprehensive and met the needs of patients and staff. Staff we spoke with explained training was delivered as e-learning with face to face practical sessions where appropriate, such as basic life support.

Sepsis training was not mandatory however, staff we spoke with could explain signs and symptoms of sepsis.

Managers monitored mandatory training and alerted staff via email when they needed to update their training. For example, we saw all staff had a training matrix. Completed modules were labelled green, those due were amber and those overdue were red.

Staff we spoke demonstrated how they accessed the electronic system to book their training on-line. All staff and managers we spoke with told us they were on trajectory to reach 100% compliance by the end of the year (March 2020). They completed a summary training compliance template each month for clinical governance meetings.

Staff we spoke with confirmed they usually had protected time to complete their training although on occasion, training was cancelled due to staffing requirements in the department.

Safeguarding

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

Safeguarding training completion rates

The trust set a target of 85% for completion of safeguarding training.

Trust level outpatient department

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 at trust level for qualified nursing staff in outpatients is shown below:

Training module name	April 2018 to March 2019				
	Eligible staff	Staff trained	Completion rate	Trust target	Met (Yes/No)
Safeguarding Children Level 1 - 3 Years	14	14	100.0%	85%	Yes
Safeguarding Adults Level 2 - 3 Years	14	14	100.0%	85%	Yes
Safeguarding Children Level 2 - 3 Years	14	13	92.9%	85%	Yes
Safeguarding Adults Level 1 - 3 Years	14	13	92.9%	85%	Yes

In outpatients, the 85% target was met for all safeguarding training modules for which qualified nursing staff were eligible.

The trust reported that there were no applicable medical staff at the trust for outpatients.

Bradford Royal Infirmary outpatient department

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 at Bradford Royal Infirmary for qualified nursing staff in outpatients is shown below:

Training module name	April 2018 to March 2019				
	Eligible staff	Staff trained	Completion rate	Trust target	Met (Yes/No)
Safeguarding Children Level 1 - 3 Years	6	6	100.0%	85%	Yes
Safeguarding Adults Level 2 - 3 Years	6	6	100.0%	85%	Yes
Safeguarding Children Level 2 - 3 Years	6	5	83.3%	85%	No
Safeguarding Adults Level 1 - 3 Years	6	5	83.3%	85%	No

Note: Please interpret completion rates with care where small numbers of staff are involved.

In outpatients, the 85% target was met for two and almost met for the remaining two of the four safeguarding training modules for which qualified nursing staff were eligible.

The trust reported that there were no applicable medical staff at the trust for outpatients.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Nursing staff received training specific for their role and they could describe different types of abuse.

We saw staff had access to safeguarding policies on the trust intranet. Staff could access guidance regarding abuse such as female genital mutilation (FGM). FGM is defined by the World Health Organisation as 'procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons.'

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. For example, we saw how staff reviewed GP referrals and reception staff we spoke with demonstrated how flags were put on the electronic patient record to identify children looked after, those on child protection plans and vulnerable adults.

In addition, we saw there was an information sharing agreement in place with the local authority regarding a list of high-risk victims of child sexual exploitation (CSE). Staff we spoke with told us a flag was placed on their electronic patient record to alert staff.

There was a policy in place for children and adults that did not attend (DNA) their appointments. Staff we spoke with told us DNA rates were high. Patients that DNA had a flag placed on their electronic record, GPs were informed and staff in the service followed up with a phone call to the patient.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff we spoke with identified the safeguarding lead and gave specific examples of safeguarding concerns they had raised. They described the reporting and documentation process they followed, which was in accordance with trust safeguarding policy.

We saw posters and leaflets to signpost patients and visitors to access help, for example, domestic and sexual abuse.

We observed chaperone posters in the departments we visited. Patients undergoing intimate examinations were always offered a chaperone and we saw this documented in the electronic patient records.

Cleanliness, infection control and hygiene

The service did not always control infection risk well, although they kept the premises visibly clean.

We observed staff cleaning nasal endoscopes in the ear, nose and throat (ENT) outpatient clinic, using a three-wipe system. This was recognised by the ENT United Kingdom society as the most widely used decontamination methodology employed in United Kingdom hospitals and was in accordance with local policy.

However, we had concerns about completion of the traceability register for the nasal endoscopes. Traceability is a process for tracking equipment used during each nasal endoscopy procedure if a patient is subsequently suspected of having, or being at high risk for, a transmissible disease. This was because fields in the traceability register were not always completed correctly. For example, in the register that was in use on the day of inspection, there were several signatures missing, some entries had dates and times missing, some staff provided their initials only and some boxes indicating each stage of the decontamination process were not ticked. This meant there was no confirmation they were completed. We brought this to the attention of staff at the time.

In addition, ENT staff we spoke with told us compliance in completion of the traceability registers had not been audited since December 2018. This meant we were unclear how the trust was assured decontamination and traceability procedures were always followed correctly.

Most consumable items we checked in the departments we visited were within expiry dates. The exception was in diabetes and endocrine clinic where we found a trolley containing several dressings and pathology bottles that had expired between July 2015 and October 2019. We brought this to the attention of staff at the time and they were removed.

Clinical areas were clean and most had suitable furnishings which were clean and well-maintained. The exceptions were in some clinical areas where we saw fabric curtains and upholstered seating which was not impermeable. However, these appeared visibly clean and in good order. Staff explained the curtains were changed by domestic staff every six months as a minimum and records were held by the domestic supervisors. We did not view these records.

There were some designated waiting areas for patients with children and we saw these areas were clean and toys were clean.

All clinical hand wash basins were compliant with infection prevention and control best practice guidance. There were hand washing posters displayed above each basin.

Clean and dirty utility rooms we inspected were clean and tidy.

The service generally performed well for cleanliness in local hand hygiene audits and environmental spot-checks. Although all areas we inspected were visibly clean, the data provided by the trust indicated 65% compliance with completion of nursing daily cleaning checklists. This concurred with our observations; we saw some apparent gaps in cleaning records, which did not always indicate when departments were closed. We brought this to the attention of staff at the time.

Staff followed infection control principles including the use of personal protective equipment (PPE). For example, all staff we saw complied with ‘bare arms below the elbows’ policy. We observed all staff washed their hands and used sanitising gel between each patient contact and when entering and exiting clinical areas.

Staff had access to non-latex gloves and aprons available in dispensers in all clinical areas.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. For example, we saw dated 'I am clean' labels in use on vital signs monitoring equipment and patient wheelchairs.

Staff we spoke with explained patients with known potentially infectious conditions such as methicillin resistant staphylococcus aureus (MRSA), were given appointments at the end of clinic and domestic staff conducted a deep clean when required.

Domestic staff worked outside of clinic hours, to minimise disruption. We saw domestic equipment was locked away when not in use.

We saw biohazard kits available to manage spillages of blood and body fluids.

Pathology samples were transported in labelled and sealed transportation bags. Staff explained these were usually sent to the trust laboratory four times a day. However, samples requiring prompt processing were taken to the laboratory immediately.

Managers we spoke with told us there was high uptake of the influenza vaccine by staff working in the service and we observed a staff vaccination clinic in progress during the inspection.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment in most areas kept people safe. However, there were gaps in emergency equipment check records. Staff generally managed clinical waste well.

Patient led assessments of the care environment (PLACE) showed that the outpatients department at this trust scored 89.9% for condition, appearance and maintenance, compared to the national average of 94.3%.

Patient led assessments of the care environment (PLACE) regarding how well the needs of a patient living with a disability were met, showed that that this hospital scored 75.6% compared to the national average of 84.2%.

Assisted access toilets had emergency call bells however, some clinical rooms did not have call bells. For example, in gynaecology clinic (women and children's outpatient department). Staff we spoke with explained they shouted for assistance if required and staff responded quickly when called. We were unclear if this had been risk assessed and staff we spoke with confirmed the lack of call bells was not on the departmental risk register.

Staff carried out daily safety checks of specialist equipment, in accordance with local policy, in most areas. The exceptions were apparent gaps in some equipment check records, which did not always indicate when the department was closed. For example, in ENT clinic, daily hypoglycaemia box checks for 2019, we saw 20 gaps in June, 30 in July, eight gaps in October, four in November and five in December. There were also apparent gaps in the daily resuscitation equipment checks. For example, 10 gaps in October and two in November. The diabetes clinic trolley had six gaps in October, 6 gaps in November and no gaps in December. We found no gaps in records in women and children's clinic. However, all resuscitation equipment trolleys had a tamper proof tag with a unique number which was recorded at each check.

The service had suitable facilities in most areas, to meet the needs of patients and families. For example, in most waiting areas we saw variable height seating, smaller seating for children and bariatric seating was available. However, there was no bariatric seating in the diabetes clinic. Staff we spoke with explained bariatric patients that used their service usually attended in their own wheelchair and they could ask to borrow from other clinics if required.

The phlebotomy clinic at this hospital, was in a small area next to the two larger clinics for haematology and oncology and vascular specialities. Although it was quiet at the time of our inspection, staff we spoke with told us the phlebotomy clinic often became very busy and lacked space, with patients waiting outside into the main hospital corridor. We raised this with managers, who told us that they were already considering options for relocating or dispersing phlebotomy services, to improve the space available.

There was a dedicated area for children in ENT with toys, books, TV and activity table at child height.

Staff we spoke with in the haematology and oncology clinic told us that doors and signage had previously been painted in bright contrasting colours (yellow and blue), to make them stand out. This was so that people living with dementia could navigate the department more easily. However, staff we spoke with explained they had been painted back to neutral colours in some places and did not know why this decision had been made.

The service had enough suitable equipment to help them to safely care for patients. Weigh scales we checked had all been calibrated within the last 12 months, except for one weigh scale in diabetes and endocrinology clinic, which had a due date sticker with 2017 on it. We brought this to the attention of staff at the time, who told us they would report it. Staff had access to speciality equipment for bariatric patients if required.

Access to dirty and clean utility rooms was restricted. Staff generally disposed of clinical waste safely. The exception was in ENT clinic, in the nasal endoscope decontamination area, where we saw a bag that contained waste, hooked over a cupboard door. This was because there was no waste bin. However, there were two pedal bins with correct liners in the treatment area. All other areas we inspected had pedal operated waste bins which contained the correct liner for the waste stream. All sharps disposal bins we inspected were assembled and labelled correctly and stored off the floor.

Fire exits were clear of obstructions and all fire extinguishers we checked were signposted and had been tested.

Assessing and responding to patient risk

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

Staff responded promptly to any sudden deterioration in a patient's health. For example, all staff we spoke with were aware how to raise the alarm and raise a cardiac arrest call by dialling 2222. Staff we spoke with told us if they needed help with a situation they called switchboard for the crisis team or security.

Specialist nurses gave patients their contact details, so they could escalate any change in condition or seek advice when they needed to.

A policy was in place to manage patients that did not attend their appointment.

Staff we spoke with explained they contacted the mental health team if they had concerns about patients requiring mental health support or those living with learning difficulties. We observed information about individual patient needs, documented in the electronic patient records.

Shift changes and handovers included all necessary key information to keep patients safe. This was shared in safety huddles.

The management team we spoke with told us clinical staff validated waiting lists, prioritised patients for review and discharged patients where appropriate. Alongside this, administrative staff reviewed waiting lists to cleanse data. This ensured patients not requiring follow up were removed. We saw a written procedure in place to support this practice.

Specialties that conducted invasive procedures such as ENT, ophthalmology and dermatology within outpatients, used world health organisation safety checklists and compliance with completion was audited. The results indicated high compliance.

Staffing

Nurse staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

Managers we spoke with explained nurses and health care assistants worked flexibly across clinics and across hospital sites in most specialties. However, in some specialties staff worked consistently in the same clinics, for example, ENT, orthopaedics and ophthalmology clinics.

Outpatient managers explained they did not use a nurse staffing tool to calculate staffing levels but managed nurse and health care assistant staffing levels depending on which clinics were running each day. Staffing was planned in advance with individual specialties and was flexible to meet the clinic needs. There was always staff allocated to cover after 5pm in the event clinics overran.

Managers booked bank and agency staff that were familiar with the service, as required. We saw detailed department-specific induction documentation for these staff on file.

Staff we spoke with told us staffing levels always felt safe and patients we spoke with told us they felt staffing levels to be adequate. We observed planned and actual staffing numbers displayed in clinics. In each of the areas we visited, planned and actual levels matched, on the day of inspection.

There were no paediatric nurses in the department but managers we spoke with explained there were always paediatricians on duty for paediatric clinics.

Staff we spoke with said they felt supported by their consultant colleagues.

Trust level

The table below shows a summary of the nursing staffing metrics in outpatients at trust level compared to the trust's targets, where applicable:

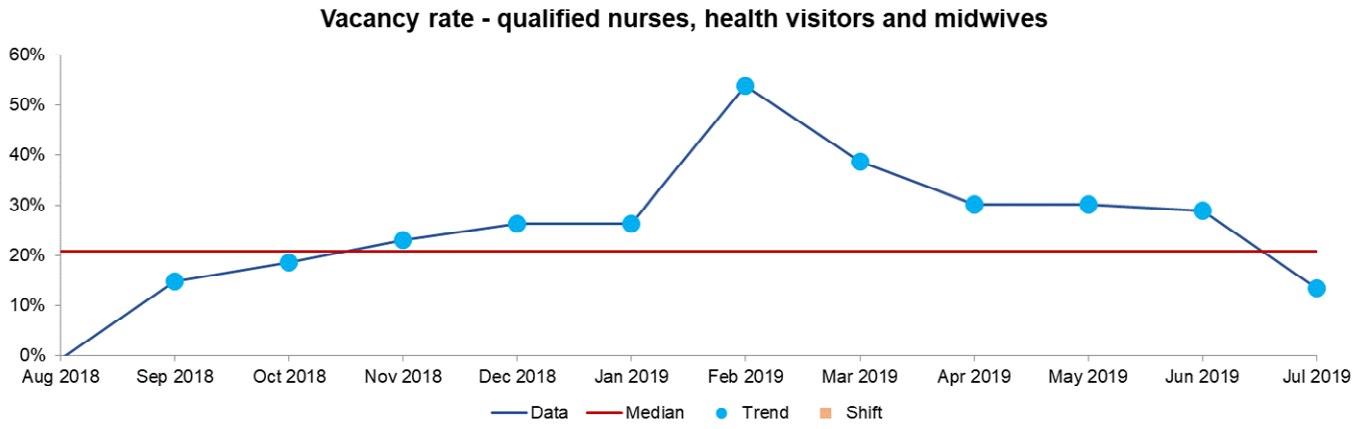
	Outpatients annual staffing metrics						
	August 2018 to July 2019						
Staff group	**Annual average establishment**	**Annual vacancy rate**	**Annual turnover rate**	**Annual sickness rate**	**Annual bank hours (% of available hours)**	**Annual agency hours (% of available hours)**	**Annual unfilled hours (% of available hours)**
Target		N/A	N/A	4.5%			
All staff	529.4	6.8%	9.4%	4.6%			
Qualified	20.0	23.7%	8.6%	5.3%	4,972	1,589	2,004

nurses					(4%)	(1%)	(2%)

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing bank agency tabs)

Nurse staffing rates within outpatients were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover, bank or agency use.

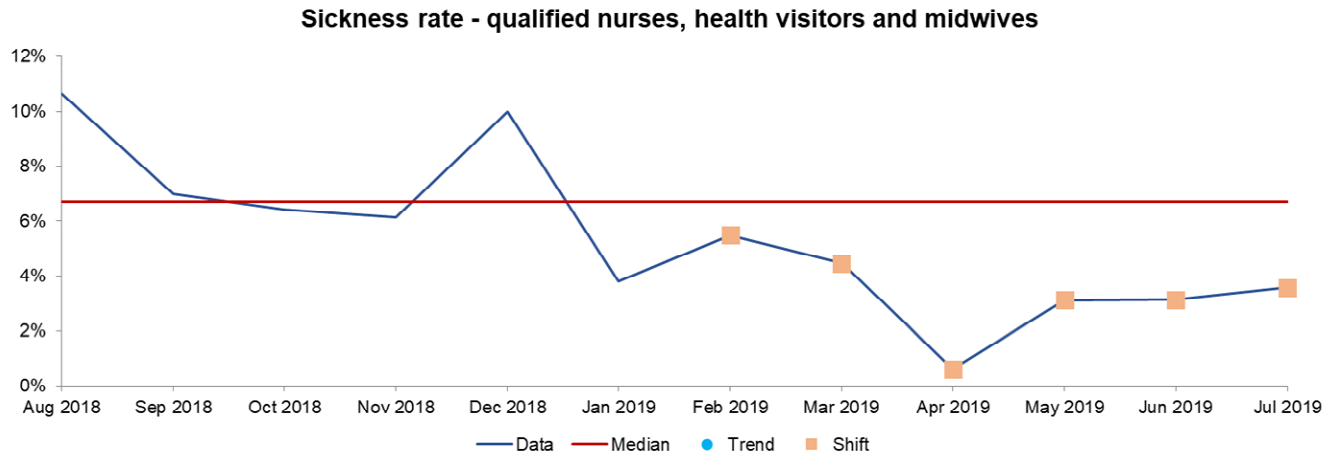
Vacancy rates



Monthly vacancy rates over the last 12 months for qualified nurses, health visitors and midwives shows a downward trend from February 2019 to July 2019. This could be an early indicator of improvement.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Sickness rates



Monthly sickness rates over the last 12 months for qualified nurses, health visitors and midwives shows a shift from February 2019 to July 2019. This could be an indicator of change.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bradford Royal Infirmary

The table below shows a summary of the nursing staffing metrics in outpatients at Bradford Royal Infirmary compared to the trust's targets, where applicable:

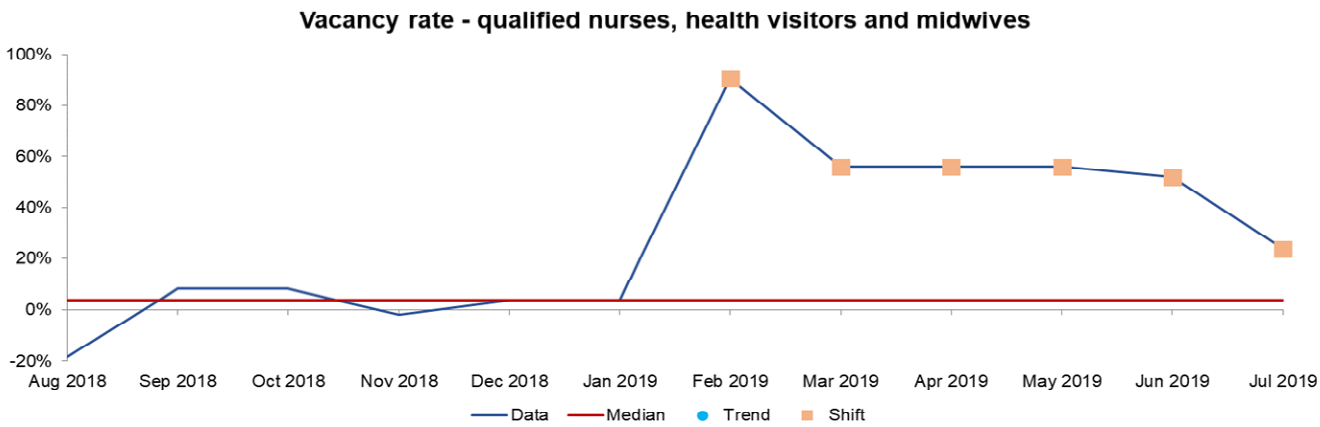
	Outpatients annual staffing metrics August 2018 to July 2019						
Staff group	**Annual average establishment**	**Annual vacancy rate**	**Annual turnover rate**	**Annual sickness rate**	**Annual bank hours (% of available hours)**	**Annual agency hours (% of available hours)**	**Annual unfilled hours (% of available hours)**
Target		N/A	N/A	4.5%			
All staff	377.3	3.9%	7.7%	4.0%			
Qualified nurses	8.0	17.8%	18.0%	6.0%	N/A*	N/A*	N/A*

NOTE*: The trust was unable to specify their bank and agency usage at site level.

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing Bank Agency tabs)

Nurse staffing rates within outpatients at Bradford Royal Infirmary were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover. (The trust was unable to specify their bank and agency usage at site level.)

Vacancy rates



Monthly vacancy rates over the last 12 months for qualified nurses, health visitors and midwives shows a shift from February 2019 to July 2019. This could be an indicator of change.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Medical staffing

The trust reported that there were no applicable medical staff at the trust for outpatients. Medical staffing levels were managed by the individual specialities across the trust.

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)

Allied health professional staffing

Trust level

The table below shows a summary of the allied health professional staffing metrics in outpatients at trust level compared to the trust's targets, where applicable:

	Outpatients annual staffing metrics August 2018 to July 2019						
Staff group	**Annual average establishment**	**Annual vacancy rate**	**Annual turnover rate**	**Annual sickness rate**	**Annual bank hours (% of available hours)**	**Annual locum hours (% of available hours)**	**Annual unfilled hours (% of available hours)**
Target		N/A	N/A	4.5%			
All staff	529.4	6.8%	9.4%	4.6%			
Allied health professionals	176.1	0.7%	N/A*	2.1%			

NOTE*: The trust did not submit turnover data for AHP's.

Note that all allied health professionals within outpatients at the trust are located at Bradford Royal Infirmary.
(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)

Records

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

Patient notes were comprehensive. Most patient records, including referral letters and all diagnostic results were electronic. A small number of patients requiring follow up still had paper records. Staff we spoke with explained these were retrieved in advance to ensure they were always available for clinic.

Staff used a smart card and individual password to access electronic records and ensure security.

However, in diabetes and endocrinology clinic, we found some patient identifiable data, including names and medical record numbers transcribed onto spreadsheets. Staff we spoke with explained they had difficulty retrieving referral data they required for reports to support business cases, direct from the electronic patient record system. Although held securely on password protected systems, we were concerned this may not comply with general data protection regulations (GDPR).

Staff we spoke with explained the outpatient service did not conduct audits of the electronic records, although the management team was aware there were some data quality issues. However, we inspected 14 electronic records. All were detailed and completed comprehensively.

Staff we spoke with told us the system did not allow closure of records unless a summary letter to the referrer was generated. These letters were dictated by consultants and sent electronically or by post.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines. However, there was no system in place to ensure security of prescription pads.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. For example, staff we spoke with explained medicines alerts were discussed as part of the daily safety huddles at 08.00.

Staff had access to British national formulary on-line. However, we also found some out of date hard copies, for example, in the diabetes clinic. We brought this to the attention of staff at the time and they were removed.

Staff stored and managed medicines in line with the provider's policy.

All medicines were prescribed by consultants or non-medical prescribers.

Minimal stocks of medicines were held in the service. No controlled drugs (CD) were stored in the areas we inspected.

Prescription forms specifically for outpatients were mostly kept securely. The exception was in the diabetes clinic where we found a pad of outpatient prescriptions in an unlocked cabinet. They were numbered sequentially but we found one prescription was missing. We brought this to the attention of the manager at the time who confirmed there was no formal logging in and out system for prescription pads. They told us this would be reported on the incident reporting system and investigated.

Staff had access to emergency medicines in the event of reactions or anaphylaxis.

Medicines were stored in locked cupboards and refrigerators. Medicines we checked in the areas we visited were within expiry dates and staff explained the department was visited weekly by a pharmacist.

Medicine refrigerator temperature checks were recorded during clinic opening times, however, records did not always indicate when the department was closed. For example, in the diabetes clinic had some apparent gaps which coincided with weekends. We brought this to the attention of staff at the time.

Some trained nurses in the service were also non-medical prescribers, (NMP's). NMP's attended twice yearly meetings and were supervised by consultants. There was also a named NMP lead in post. Non-medical prescribing was audited annually.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately.

Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them, in line with trust policy. For example, staff we spoke with said us the trust advocated a no-blame, positive reporting culture and described specific examples of incidents they had reported.

They explained learning from incidents and national safety alerts was shared at the daily safety 8am huddles and more widely via 'learning matters' bulletin and email rapid response bulletins from the risk management team. They told us about changes to practice resulting from incident reporting. For example, changes to information provided in outpatient appointment letters to ensure patients were clearer about where to attend.

Staff also described learning and change to practice following a national patient safety alert. This concerned pulse oximeter probes used on ears and toes, instead of on fingers, as intended. Staff explained the department was in the process of obtaining dedicated ear probes and new equipment for patient observations as the current equipment was not compatible for use with ear probes.

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From August 2018 to July 2019, the trust did not report any never events for outpatients.

(Source: Strategic Executive Information System (STEIS))

Staff we spoke with were not aware of any never events that had happened anywhere else within the trust.

Breakdown of serious incidents reported to STEIS
Trust level
In accordance with the Serious Incident Framework 2015, the trust did not report any serious incidents (SIs) in outpatients which met the reporting criteria set by NHS England from August 2018 to July 2019.

(Source: Strategic Executive Information System (STEIS))

Staff understood the duty of candour. 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. This regulation requires staff to be open, transparent and candid with patients and relatives when things go wrong. Local policy and national documents relating to duty of candour were available via the trust intranet. Staff we spoke with were aware of the need to be open and honest when something went wrong.

Safety thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

Formal safety thermometer reporting was not used in outpatients. However, the service did record and display local results following hand hygiene audit.

In fracture clinic, staff we spoke with explained 'harm free care statistics' were monitored and

displayed. The most recently displayed statistics were for September 2019. 98% of patients experienced harm free care, considering catheter acquired urinary tract infections, pressure ulcers, falls and venous thrombo-embolisms (blood clots).

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice.

Staff followed up-to-date policies and guidance to plan and deliver high quality care according to best practice and national guidance. For example, policies we saw were referenced to best practice guidance. Managers we spoke with explained clinical specialty guidance was reviewed every two years. The governance manager kept a tracker of national institute for health and care excellent (NICE) guidance and communicated it out via a virtual guidelines group.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health.

There was drinking water available for patients in the outpatient area waiting areas we visited.

Information about patient nutritional and hydration status was communicated to outpatients in GP referral letters and was available to staff in the electronic patient record.

Staff we spoke with told us they could request food and drinks from catering services for patients with diabetes or those waiting for hospital transport. In addition, there were tea bars run by hospital volunteers where patients and visitors could purchase drinks and snacks.

Staff we spoke with told us they arranged support from dieticians and speech and language therapists for patients who needed their input to improve their nutrition and hydration.

Pain relief

Staff assessed patients to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools.

Staff assessed patients' pain using recognised pain tools and gave pain relief in line with individual needs and best practice. For example, we observed consultants assessing children by asking both the child and the parent about the child's level of pain and asking them to score 1-4. However, nursing staff we spoke with said they assessed pain using a score of 0-10 and interpreted body language of patients unable to state a pain score.

Different options for pain relief were also discussed and staff administered simple analgesia if required and prescribed during consultation.

Patient outcomes

Staff monitored the effectiveness of care and treatment.

National audit activities were completed by the overarching clinical specialities, and outcomes were shared with outpatient teams. For example, female stress urinary incontinence national audit, and

national ophthalmology database audit. Recommended actions were implemented where appropriate.

Staff we spoke with told us they participated in local hand hygiene audits and departmental cleanliness audits. We reviewed the results for September to November 2019 and all areas exceeded their target compliance rates.

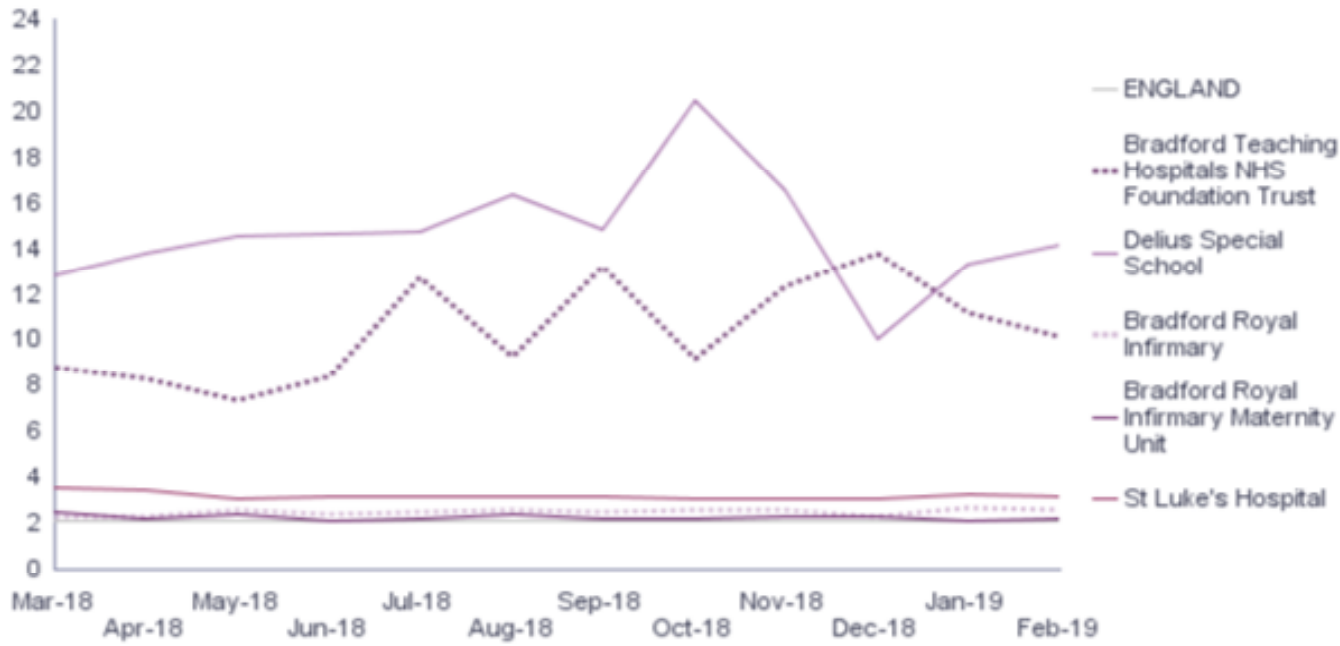
Follow-up to new rate

From March 2018 to February 2019 the following follow up rates by site are compared to the England average:

- Bradford Teaching Hospitals NHS Foundation Trust was higher than the England average.
- Bradford Royal Infirmary was slightly higher than the England average.
- St Luke's Hospital was slightly higher than the England average.
- Bradford Royal Infirmary maternity unit was similar to the England average.
- Delius Special School was higher than the England average.

Follow-up to new rate, Bradford Teaching Hospitals NHS Foundation Trust.

(Source: Hospital Episode Statisti



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Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Staff we spoke with told us they received clinical supervision from band six and band seven nursing colleagues.

Non-medical prescribers we spoke with explained they attended non-medical prescriber updates twice a year and received supervision from named consultants.

We saw staff received competency training in specialist skills such as ear syringing, micro-suction, intravitreal injection, administration of Botox and skin-prick allergy testing. Consultants provided this training within the department and signed staff off when competent.

All health care assistants were required to complete a 'care certificate' training programme during their probationary period, covering all competencies required for their role.

Managers gave all new staff a full induction tailored to their role before they started work. We saw induction records within the service.

Appraisal rates

Managers supported staff to develop through yearly, constructive appraisals of their work.

From August 2018 to July 2019 92.1% of staff within outpatients department at the trust received an appraisal. The trust target was 95% by December each year.

The breakdown by staff group can be seen in the table below:

Trust level

Staff group	August 2018 to July 2019				
	Staff who received an appraisal	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Healthcare Scientists	20	20	100.0%	95%	Yes
Add Prof Scientific and Technic	2	2	100.0%	95%	Yes
Estates and Ancillary	1	1	100.0%	95%	Yes
Nursing and Midwifery Registered	56	57	98.2%	95%	Yes
Allied Health Professionals	47	49	95.9%	95%	Yes
Administrative and Clerical	127	135	94.1%	95%	No
Additional Clinical Services	61	77	79.2%	95%	No

Please interpret completion rates with care where small numbers of staff are involved.

Bradford Royal Infirmary outpatient department

Staff group	August 2018 to July 2019				
	Staff who received an appraisal	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Add Prof Scientific and Technic	1	1	100.0%	95%	Yes
Estates and Ancillary	1	1	100.0%	95%	Yes
Healthcare Scientists	20	20	100.0%	95%	Yes
Nursing and Midwifery Registered	33	34	97.1%	95%	Yes
Administrative and Clerical	17	19	89.5%	95%	No
Additional Clinical Services	32	43	74.4%	95%	No
Allied Health Professionals	1	2	50.0%	95%	No

Please interpret completion rates with care where small numbers of staff are involved.

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

Multidisciplinary working

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

Staff held regular and effective multidisciplinary team (MDT) meetings to discuss patients and improve their care. For example, nurse specialists we spoke with explained how they linked with the women's health team and attended weekly multidisciplinary meetings in collaboration with the regional cancer centre. They also linked with a cancer support group in Bradford and had links to mental health, learning disability, autism and dementia services.

ENT consultants we spoke with told us they attended monthly MDT meetings with audiology colleagues and quarterly meetings with paediatric speciality colleagues.

Seven-day services

Outpatient services were not always available seven days a week.

Most outpatient clinics operated between 08.30 – 17.30 from Monday to Friday. There were no routine evening clinics at this hospital, but there were occasional weekend ENT outpatient clinics to improve access for patients.

Staff we spoke with told us they had heard there may be plans for more clinics during evenings and weekends, but this was not confirmed by managers we spoke with.

Staff called for support from doctors and other disciplines, during outpatient operational hours. For example, specialist dieticians, psychologists, mental health services and diagnostic tests.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support in patient areas. For example, there were posters and leaflets covering a range of topics, including smoking cessation, alcohol consumption management, mental health and wellbeing, obesity and weight management, dementia awareness, support for carers and relatives, local cancer support groups, condition-specific leaflets and medicine information leaflets.

People were involved in monitoring their own health, including health assessments and checks, where appropriate and necessary. For example, patients we spoke with that were living with long term conditions, told us staff worked with them to increase their understanding of their condition. This enabled them to identify if their condition was changing. If so, they were encouraged to contact the service directly to access an earlier appointment than their planned routine follow up.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

Consent to planned surgery was initiated in the outpatient department.

We observed staff gained consent from patients for their care and treatment, using simple terminology, in accordance with legislation and best practice guidance.

We saw how staff engaged children in the consent process. For example, we observed they explained interventions in a way children understood and checked they were happy to proceed.

Staff clearly recorded consent in the patients' records.

Mental Capacity Act and Deprivation of Liberty Safeguards training completion

Nursing staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

Trust level

The trust set a target of 85% for completion of Mental Capacity Act (MCA) training.

The trust did not supply training data regarding DOLS training modules.

A breakdown of compliance for MCA training modules from April 2018 to March 2019 at trust level for qualified nursing staff in outpatients is shown below:

Training module name	April 2018 to March 2019				
	Eligible staff	Staff trained	Completion rate	Trust target	Met (Yes/No)
Mental Capacity Act Level 2	14	14	100.0%	85%	Yes
Mental Capacity Act Level 1	14	14	100.0%	85%	Yes

In outpatients the target was met for all the MCA training modules for which qualified nursing staff were eligible.

The trust reported that there were no applicable medical staff at the trust for outpatients.

Bradford Royal Infirmary outpatient department

The trust set a target of 85% for completion of Mental Capacity Act (MCA) training.

A breakdown of compliance for MCA training modules from April 2018 to March 2019 at Bradford Royal Infirmary for qualified nursing staff in outpatients is shown below:

Training module name	April 2018 to March 2019				
	Eligible staff	Staff trained	Completion rate	Trust target	Met (Yes/No)
Mental Capacity Act Level 2	6	6	100.0%	85%	Yes
Mental Capacity Act Level 1	6	6	100.0%	85%	Yes

In outpatients the target was met for all of the MCA training modules for which qualified nursing staff were eligible.

The trust reported that there were no applicable medical staff at the trust for outpatients.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Is the service caring?

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

All patients we spoke with during the inspection told us staff treated them with respect and maintained their dignity and privacy. For example, they ensured clinic doors were closed during appointments and used curtains in treatment rooms.

We observed how staff gave care in a kind gentle way, which reassured a child and their parent while the child was receiving treatment. Children were given a bravery sticker after their treatment.

Waiting areas were situated away from reception desks so when reception staff spoke with patients, they maintained their privacy and confidentiality as far as possible.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Staff we spoke with told us that chaperones were available and provided as necessary. We saw this recorded in individual patient records. Staff accessed information about the responsibilities of chaperones in the dignity and respect trust policy. However, staff we spoke with explained they did not receive formal chaperone training.

Staff described situations when they identified patients who may have mental health needs and the steps they took, to ensure those patients were safe while maintaining their dignity.

All patients we spoke with during this inspection gave positive feedback about the care they received. The friends and family test (FFT) results for outpatients at this trust showed that in October 2019, 97% of respondents were extremely likely or likely to recommend the service.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it.

Specialist nurses provided care and support for patients. For example, they supported gynaecological cancer patients from the point of diagnosis and through the cancer pathway. We saw patients were offered contact details, so they could call specialist nurses if they had any questions or concerns.

They also signposted patients to other charitable support networks in the locality. Staff referred patients to psychologists at the trust if required.

There was a quiet room available with seating, for patients to use if they were anxious or worried when visiting the department. Staff we spoke with explained they also used it for private discussion with patients and those who received bad news. This was to provide privacy if they were distressed.

Staff we spoke with understood how to support patients who may need additional support. For example, patients living with dementia, learning disabilities or vulnerable adults.

Staff described being adaptable to the needs of patients. For example, they provided separate waiting areas for distressed or anxious patients, and fast- tracked those that were anxious or phobic, living with dementia or learning disabilities.

We saw leaflets available which addressed issues associated with patient diagnosis, such as anxiety, changes in physical appearance, carer or relative support and financial concerns.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. Patients we spoke with told us staff explained things clearly and felt involved in making decisions about care and treatment. We saw patients were given the choice to bring a relative or friend with them to their appointments. A relative we spoke with told us they felt included and involved during consultations.

Staff ensured there was an interpreter at appointments if necessary, so patients and their relatives could understand everything during consultation. Staff we spoke with told us the service was easy to access.

Patients we spoke with confirmed receipt of letters sent between the hospital and their GP, if they had requested this.

There was a wide range of patient information leaflets available about a variety of health conditions. We observed posters in some areas displaying anatomy and physiology to aid patients' understanding of their condition.

Is the service responsive?

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served.

Clinics were mostly provided during core hours, with occasional ENT clinics at weekends.

Waiting lists were held by speciality and the method of care delivery was face to face.

The service minimised the number of times patients needed to attend the hospital, by ensuring they accessed the required staff and tests on one occasion. For example, there were 'one stop' services in the early arthritis clinic, termination of pregnancy clinic and breast clinic.

The service had systems to help care for patients in need of additional support or specialist intervention.

Managers ensured patients who did not attend appointments were contacted, in accordance with local policy.

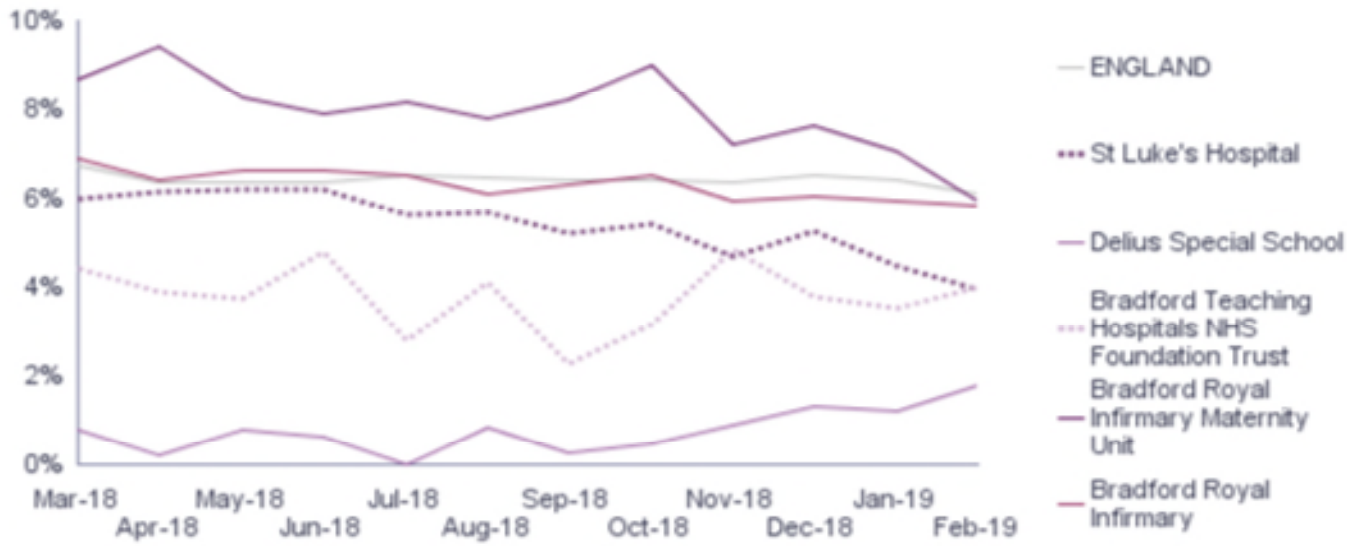
Did not attend rate

From March 2018 to February 2019 the following 'did not attend' rates per site can be compared:

- Bradford Teaching Hospitals NHS Foundation Trust was lower than the England average.
- Bradford Royal Infirmary was similar to the England average.
- St Luke's Hospital was lower than the England average.
- Delius Special School was lower than the England average.
- Bradford Royal Infirmary maternity unit was higher than the England average.

The chart below shows the 'did not attend' rate over time:

Proportion of patients who did not attend appointment, Bradford Teaching Hospitals NHS Foundation Trust



(Source: Hospital Episode Statistics)

Meeting people's individual needs

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

Staff made sure patients received the necessary care to meet all their needs. For example, staff we spoke with described how patients living with learning difficulties were given appointment times to minimise disruption their usual routines. In addition, they signposted cancer patients to a wig service if needed and had access to complementary therapies such as massage and reflexology. Patients that needed help to manage finances while receiving treatment received advice on how to access benefits.

Clinics were designed to meet the needs of patients living with dementia. For example, Staff supported patients living with dementia and learning disabilities by using 'this is me' documents and patient passports. Patients that had these documents were flagged on their electronic patient record.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Information was available in accessible formats if required. Appointment letters provided contact details and information about when and where to attend. Reception areas we visited, had a hearing loop system installed.

Staff we spoke with understood the local demographic and accessed information leaflets in languages spoken by the patients and local community. In addition, we noted flags on the electronic patient record if an interpreter was required. Interpreters usually attended in person, but staff also accessed interpreters on line and by telephone.

Access and flow

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

The referral to treatment time (RTT) data for December 2019 showed the trust was at 88% against a target of 92%. RTT and associated action plans were discussed routinely in the clinical business unit governance meetings and this was minuted.

Managers monitored waiting times and made sure patients could access services when needed. For example, in gynaecology outpatients, there was a fast track system which ensured those with a possible cancer diagnosis were seen within two weeks of referral.

Patients were triaged by staff in central bookings and a specialty consultant. Managers we spoke with told us the service was currently meeting their two-week wait target.

We observed waiting areas and noted sufficient flow. No patients were standing while waiting. Staff we spoke with explained if clinics were delayed by 20 minutes, they apologised and made waiting patients aware of the reason for the delays.

Outpatient appointment bookings were managed centrally. However, staff could also book patients into rapid access to clinics where required. For example, the diabetes foot ulcer clinic.

There were some transition clinics for young people from the age of 16, transitioning into adult services. For example, in the diabetes clinic, these were held every three months.

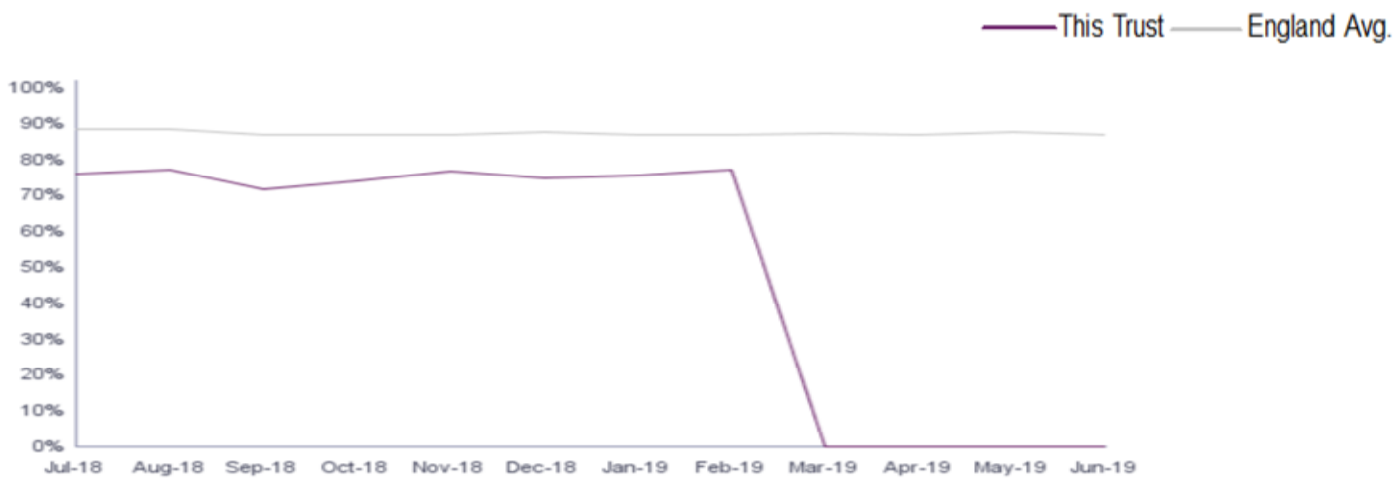
Managers monitored cancellations of clinics. We reviewed data for September to November 2019 and saw the rate for cancellations under six weeks was 1.65%. Cancellations over six weeks were 2.72%. The main reason was staff annual leave.

Referral to treatment (percentage within 18 weeks) – non-admitted pathways

From July 2018 to February 2019 the trust's referral to treatment (RTT) time for non-admitted pathways fluctuated. From March 2019 the trust has not submitted any non-admitted RTT data nationally. This was because NHS Improvement/NHS England agreed reporting requirements with the trust. However, although incomplete pathway data has been submitted during this period.

Incomplete pathway data is however reported by Trusts nationally.

Referral to treatment rates (percentage within 18 weeks) for non-admitted pathways, Bradford Teaching Hospitals NHS Foundation Trust



(Source: NHS England)

Referral to treatment (percentage within 18 weeks) non-admitted performance – by specialty

The following specialty was above the England average for non-admitted pathways RTT (percentage within 18 weeks):

Specialty grouping	Result	England average
Geriatric Medicine	99.4%	94.9%

The following sixteen specialties were below the England average for non-admitted pathways RTT (percentage within 18 weeks):

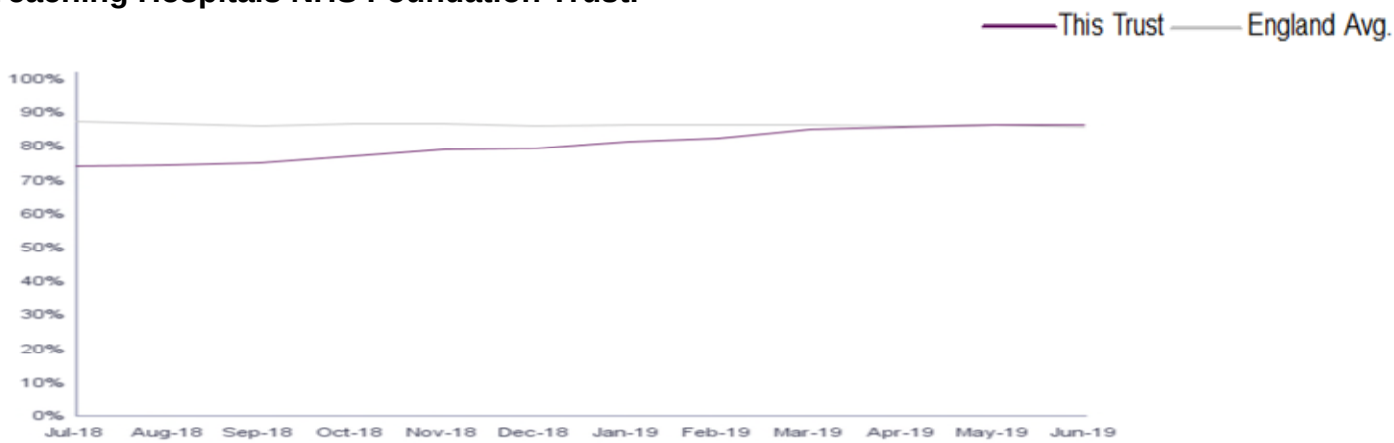
Specialty grouping	Result	England average
Gynaecology	84.1%	90.8%
Dermatology	83.5%	87.6%
General Medicine	82.6%	90.9%
Other	81.0%	89.6%
Oral Surgery	79.8%	79.9%
Ophthalmology	75.2%	88.4%
Rheumatology	74.7%	85.6%
Trauma & Orthopaedics	74.0%	85.5%
Plastic Surgery	70.8%	90.1%
Urology	70.1%	84.1%
Thoracic Medicine	67.1%	85.9%
Cardiology	64.4%	85.2%
Gastroenterology	61.3%	80.7%
Ear, Nose & Throat (ENT)	57.0%	83.3%
General Surgery	51.9%	88.3%
Neurology	51.2%	77.0%

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – incomplete pathways

From July 2018 to April 2019 the trust's referral to treatment time (RTT) for incomplete pathways has been worse for each month than the England overall performance. However, the overall trajectory has been improving and in April 2019 the trust achieved the same performance (86.4%) as the England average. Subsequently, in June 2019 was trust (86.4%) was slightly higher than the England average (85.8%).

Referral to treatment rates (percentage within 18 weeks) for incomplete pathways, Bradford Teaching Hospitals NHS Foundation Trust.



(Source: NHS England)

Referral to treatment (percentage within 18 weeks) incomplete pathways – by specialty

Three specialties were above the England average for incomplete pathways RTT (percentage within 18 weeks):

Specialty grouping	Result	England average
Geriatric Medicine	99.4%	95.8%
Oral Surgery	85.8%	82.0%
Trauma & Orthopaedics	82.5%	81.3%

Fourteen specialties were below the England average for incomplete pathways RTT (percentage within 18 weeks):

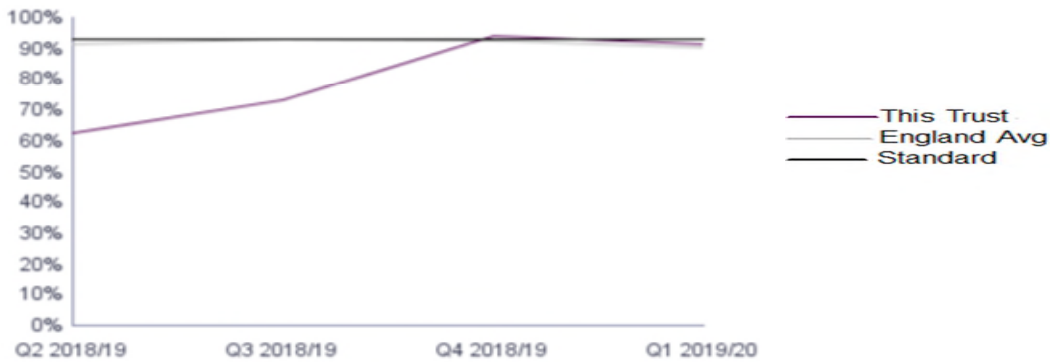
Specialty grouping	Result	England average
Gynaecology	87.3%	87.5%
General Medicine	85.1%	91.2%
Cardiology	83.1%	89.3%
Other	82.7%	88.8%
Rheumatology	82.1%	90.8%
Dermatology	81.6%	89.3%
Urology	79.7%	84.6%
Ophthalmology	79.1%	86.2%
Gastroenterology	78.8%	87.7%
Plastic Surgery	78.8%	82.2%
Neurology	77.8%	86.2%
Thoracic Medicine	77.6%	89.2%
Ear, Nose & Throat (ENT)	70.0%	83.6%
General Surgery	60.9%	83.9%

(Source: NHS England)

Cancer waiting times – Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers)

Up until Q4 2018/19 the trust has performed worse than both the 93% operational standard for people being seen within two weeks of an urgent GP referral and the England average. The graph below shows an improving trajectory and from Q4 2018/19 onwards, performance was similar to the England average and the 93% operational standard.

Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers), Bradford Teaching Hospitals NHS Foundation Trust

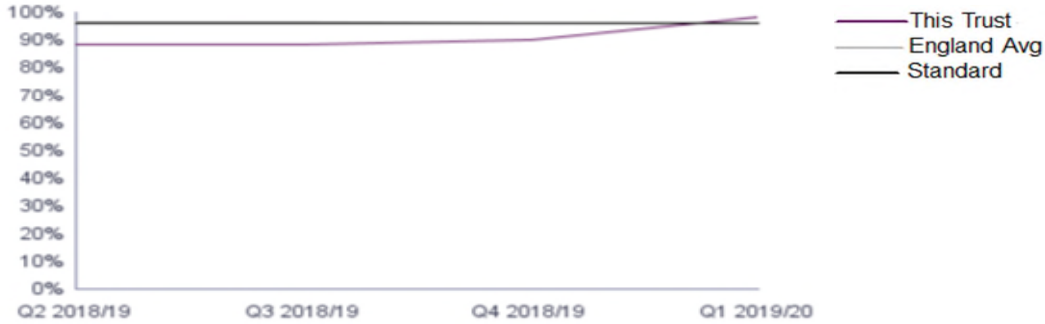


(Source: NHS England – Cancer Waits)

Cancer waiting times – Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers)

Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers), Bradford Teaching Hospitals NHS Foundation Trust

The chart below shows that from Q2 2018/19 to Q4 2018/19 the trust was performing worse than both the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a diagnosis (decision to treat) and the England average. However, Q4 2018/19 the trajectory has been improving with the performance in Q1 2019/20 being above the operational standard and the England average.

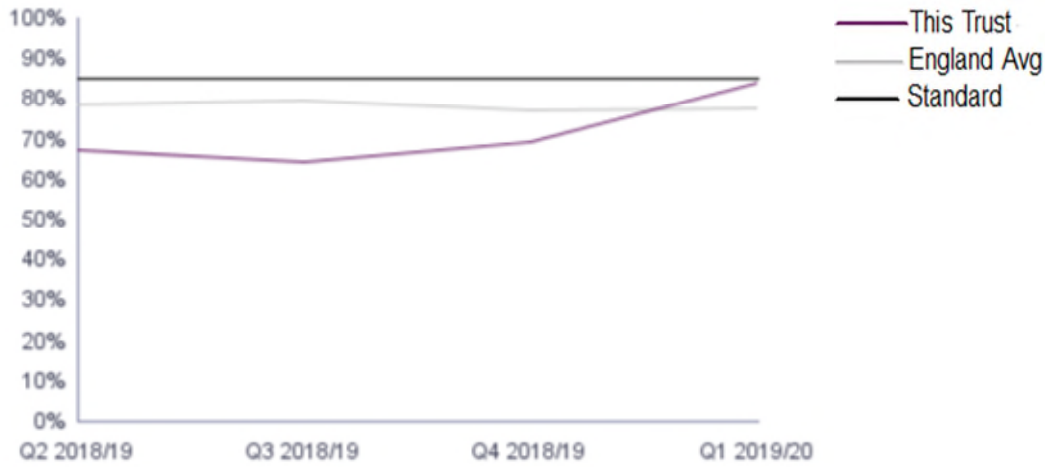


(Source: NHS England – Cancer Waits)

Cancer waiting times – Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment

The chart below shows that from Q2 2018/19 to Q4 2018/19, the trust is performing worse than both the 85% operational standard for patients receiving their first treatment within 62 days of an urgent GP referral and the England average. Q1 2019/20 shows that an improvement has occurred and the trust is now similar to the operational standard and better than the England average.

Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment, Bradford Teaching Hospitals NHS Foundation Trust



(Source: NHS England – Cancer Waits)

Learning from complaints and concerns

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

Patients and relatives we spoke with knew how to complain or raise concerns if they needed to. Feedback and complaints could be submitted via links on the trust's patient experience web page.

The service displayed clear information about how to raise a concern.

Staff understood the policy on complaints and knew how to handle them. Staff we spoke with

explained most complaints related to waiting times in clinics. They told us if a delay reached 20 minutes, they apologised to patients that were waiting and explained the reason for the delay. If patients remained unsatisfied, staff escalated patient concerns to the team leader, who saw the complainant personally.

Trust level

From August 2018 to July 2019 the trust received 54 complaints in relation to outpatients at the trust (10.3% of total complaints received by the trust). The trust took an average of 62.9 working days to investigate and close complaints. This was in line with their complaints policy, which stated responses to complainants would be within a maximum period of six months.

A breakdown of complaints by type is shown below:

Type of complaint	Number of complaints	Percentage of total
Surgical Group	20	37.0%
Appointments including delays and cancellations	13	24.1%
Patient Care including Nutrition/Hydration	6	11.1%
Communications	5	9.3%
Values and Behaviours (Staff)	2	3.7%
Accident and Emergency	2	3.7%
Anaesthetics	1	1.9%
Dental Group	1	1.9%
Paediatric Group	1	1.9%
Facilities Services	1	1.9%
General Medicine Group	1	1.9%
Waiting Times	1	1.9%
Total	**54**	**100.0%**

Out of these 54 complaints in relation to outpatients, all referred to Bradford Royal Infirmary apart from the following fourteen complaints from St Luke's Hospital:

Type of complaint	Number of complaints	Percentage of total
Appointments including delays and cancellations	4	28.6%
Communications	2	14.3%
Surgical Group	2	14.3%
Patient Care including Nutrition/Hydration	2	14.3%
Dental Group	1	7.1%
Anaesthetics	1	7.1%
Waiting Times	1	7.1%
General Medicine Group	1	7.1%
Total	**14**	**100.0%**

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Number of compliments made to the trust

From August 18 to July 2019 there were 17 compliments about outpatients at the trust. A breakdown of compliments by site is below:

Site	Number of compliments	Percentage of total
St Luke's Hospital	10	58.8%
Bradford Royal Infirmary	7	41.2%

Total	**17**	**100.0%**

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Is the service well-led?

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

Staff we spoke with told us they felt there was good leadership within the service. They said leaders were visible, supportive and approachable.

Head of nursing and matrons met daily at a management huddle and discussed how any challenges were managed. Topics included incidents, compliments, staffing, equipment issues, daily operational issues and safety alerts.

Vision and strategy

The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

The trust vision and values were summarised within four key goals which were displayed on posters throughout the department. These were best quality services, seamless access, healthy as possible and for staff, best place to work. Staff we spoke with were familiar with the trust values.

Outpatient managers we spoke with explained outpatient services were incorporated into the overarching trust strategy and those of the individual specialities.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care.

Staff we spoke with told us they felt morale to be ‘very good’ and they had not experienced bullying within the service. They said the culture encouraged openness and honesty at all levels.

Staff we spoke with said they felt able to raise concerns with managers without fear of retribution. We saw some of these concerns documented on the risk register.

They told us results of the staff survey were fed back and managers promoted staff well being through staff focused social events.

Governance

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

Managers we spoke with explained due to the structure of the trust, they did not hold outpatient specific governance or team meetings. However, clinical business unit governance and team meetings included care provided within inpatient and outpatient settings.

Senior staff we spoke with told us they attended monthly clinical governance meetings. Junior staff, healthcare assistants and clinicians were also encouraged to attend.

Management of risk, issues and performance

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

We reviewed the departmental risk registers for planned and unplanned care. These showed control measures in place to reduce the impact of the risks and risks were reviewed regularly.

There was alignment between the recorded risks and what staff we spoke with perceived as risks. For example, a risk relating to the environmental limitations in the diabetes clinic. This had been on the risk register since 2014 but had been escalated to the corporate risk register.

Staff accessed the trust business continuity framework and guidance on the intranet. We saw an incident response plan. This had an action card, which described actions for outpatient teams in the event of a major incident.

Information management

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

Staff had access to required information systems. For example, the trust intranet, for policies, procedures, national guidance and latest trust news. Staff had support from an internal information technology team when required.

The service had performance reports. For example, patient tracking list reports, which enabled the service to monitor the waiting lists and understand where there were challenges.

Information systems were used to support safe patient care. For example, staff accessed electronic patient records and an electronic incident reporting system.

Most staff we spoke with told us the implementation of the electronic patient record (EPR) system went smoothly. The exception was in diabetes clinic podiatry service, where a GP/community system in use was incompatible with EPR. Staff we spoke with told us this resulted in duplication, because they had to transfer records on to EPR. However, this was not recorded as a risk on the risk register.

Managers we spoke with explained the introduction of EPR had reduced the need for paper records significantly. There was a clinical lead on medical records project.

We reviewed incident reports to the national reporting and learning system (NRLS) and the strategic executive information system (StEIS), for the previous 12 months. We found there was one incident report regarding information governance relating to outpatients and the service had investigated and actioned the potential breach.

All electronic information systems were accessed by individual smart card and password. We observed that principles of the general data protection regulations (GDPR) were embedded.

Engagement

Leaders and staff actively and openly engaged with patients, staff and the public to plan and manage services.

Friends and family test feedback cards were used across the trust. Staff were proactive and acted to increase the response rate to the friends and family test. For example, they recognised regular attenders may not have realised that they could complete a feedback card after every visit. Staff changed the wording to attract responses, to ‘we want to know about your care today’. We saw

some staff wore badges with this phrase on them to raise awareness of the importance of patient feedback.

There was a patient advice and liaison service for complaints and concerns which was highlighted on various posters and leaflets.

Patient feedback was sought and utilised to make changes to services. For example, patients suggested improving availability of food and drink within the department. In response, the hospital introduced tea bars, staffed by hospital volunteers. The money raised by the tea bars was donated back to the hospital in the form of equipment to improve patient experience.

Following a patient survey, the service identified areas for improvement in communication between staff and patients in the haematology and oncology clinic. They addressed each of the points raised.

The service utilised patient feedback from patient-led assessments of the care environment (PLACE). For example, handrails were installed and refurbishments completed in the orthopaedic clinic.

The trust liaised with their local Healthwatch division to learn from case studies of patient experience.

Staff we spoke with told us senior leaders were accessible. We heard that board level executive directors and non-executive directors visited the outpatient department on a planned and unplanned basis, and engaged with staff during the walkabouts.

All staff we spoke with were aware of a weekly ‘let’s talk’ magazine, to engage staff at all levels of the organisation.

Staff we spoke with told us their ideas for improvement were acted upon by managers. For example, where two consultants had the same name, staff suggested moving consultants’ clinic rooms to make it clearer to patients who they were going to see.

Learning, continuous improvement and innovation

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

Staff received recognition for innovation and patient experience improvements in the trust annual ‘Bradford’s brilliance’ awards and employee of the month. For example, a staff member received an award for their plaster cast care- compass, which identified patients at risk from pressure damage.

Some staff we spoke with said they were supported to develop their career through further post graduate study.

The service supported student nurses on placement, by allocating mentors to work with them. We saw students were given a structured programme which ensured they gained experience in a variety of outpatient settings.

The trust implemented an outpatient improvement programme as one of three main transformational improvement initiatives within the trust’s improvement agenda. The aim of the programme was to improve the utilisation of outpatient clinics and reduce the number of unnecessary attendances.

Examples of some of the improvement work streams included a two-way text messaging, booking and clinic utilisation tool. This allowed patients to confirm their attendance at booked appointments and acted as a reminder to attend.

The service also trialled ‘virtual clinics’ which converted a four-hour face to face clinic to a combined three -hour face to face clinic plus a one hour long telephone assessment clinic. Analysis showed an increase of two follow-up appointments per session.

St Luke's

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Bradford
BD5 0NA

Tel: 01274 734744

www.bradfordhospitals.nhs.uk/our-hospitals/st-lukes-hospital/

Outpatients

Facts and data about this service

The trust offers acute outpatient services at Bradford Royal Infirmary, Shipley Hospital and St Luke's Hospital. The table below shows the services provided at each site:

Site	Team	Services
Bradford Royal Infirmary	Diabetes & Endocrinology Unit	The department provides multidisciplinary outpatient services to adults with diabetes and endocrine disorders. The diabetes team provide a service for newly diagnosed patients and those with existing diabetes. It also offers an insulin pump service, renal diabetes support, a service for adolescent patients and a service for those with rare or atypical forms of diabetes and all patients with complex diabetic needs. The endocrinology team deal with a wide range of problems including pituitary dysfunction, adrenal disorders, thyroid disorders, reproductive disorders, calcium metabolism, osteoporosis and trans gender reassignment.
	Adult Outpatients	The adult outpatients facility is the route from primary care into secondary care outpatient consultation, follow up review, diagnostic testing and treatment. It is consultant led and supported by a multi-disciplinary team. All rooms are equipped with Electronic Patient Record (EPR) and PACS/Pathology IT facilities.
	Audiology	A head and neck outpatient area with HTML standard audiology booths based within the ear nose and throat (ENT) outpatients section. The consultant led service is supported by a multi-disciplinary team of nursing, allied health professionals (AHP) and clinical scientists. A child friendly play area is provided for our paediatric visitors and the decor is colourful and inviting.
	Bradford Macular Unit	The Macula Centre is for the people of Bradford and beyond, and it means that patients with suspected wet macular degeneration, will

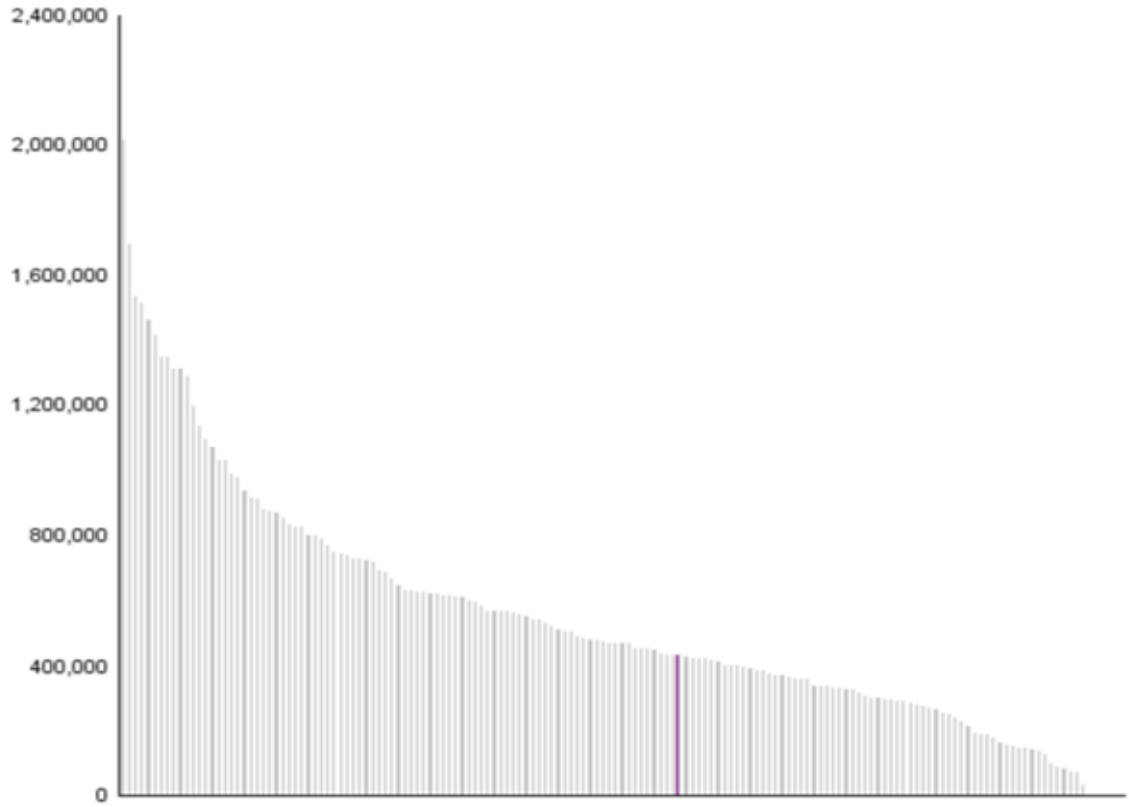
		be seen and treated for this condition more quickly, improving the success of the treatment.
	ENT and Ophthalmology Outpatients	A head and neck outpatient area with both an ophthalmology suite and ENT outpatients section. It is a consultant led service and is supported by a multi-disciplinary team of nursing, AHP and clinical scientists. A child friendly play area is provided for paediatric visitors. This is the route from primary care into secondary care outpatient consultation, follow up review, diagnostic testing and treatment.
	Haematology & Oncology Clinics - Out Patients	This facility provides specialist clinics including: lymphoma, haemostasis, myeloid, myeloma and chronic lymphatic leukaemia, anaemia and haemoglobin clinics. The consultant led team is supported by an multidisciplinary team (MDT) consisting of specialist nurses, nursing, AHPs and clinical scientists.
	Trauma and Orthopaedic Outpatients	The trauma and orthopaedics outpatient area is co-located with the emergency department (ED), radiology and the plaster room to enable outpatient consultation, follow up review, fracture clinics, diagnostic testing and treatment. The service is consultant led, supported by a multi-disciplinary team.
	Plastics and Trauma Dressing Clinic	A dedicated plastics and trauma outpatient follow up and dressing clinic, accepting patients directly from ED for treatment. The team provides an outreach response to support the ED team during patient consultations and trauma calls.
Shipley Hospital	Outpatients	Physiotherapy, colorectal, out patients and GP direct access X-ray services. This is an outreach location providing the opportunity to deliver care closer to home from this locality. The facility provides capacity for outpatient consultation, follow up review, diagnostic testing and treatment. It is consultant led and supported by a multi-disciplinary team.
St Luke's Hospital	Dermatology Outpatients	The dermatology service is a multi-disciplinary team delivering a wide range of specialist dermatological services predominantly within a dedicated outpatient setting. The service provides dermatology support to patients referred from primary care who have been assessed via a GP with special interest in dermatology for secondary care and also a skin cancer fast track and follow up service. Diagnostics, procedures and specialist treatments are provided within this location.
	HIV Service	"Trinity@StLukes is the Bradford clinic which treats and cares for HIV positive people. Around 420 patients attend the clinic and patients are seen following their HIV positive diagnosis in a variety of settings from GP surgeries, antenatal clinics, sexual health screening, and even home testing kits which are now available.
	Adult Outpatients	Services include a consultation, follow up review, diagnostic testing and treatment. It is consultant led and supported by a multi-disciplinary team. All rooms are equipped with EPR and PACS/Pathology IT facilities.
	Orthotics	The orthotics service is current based at St Luke's providing Orthotic devices to patients to provide pressure relief, correct or accommodate deformity and to improve function.
	Orthodontics	The orthodontic department in St Luke's is a dedicated area with a number of treatment chairs including one specifically designed to manage bariatric patients. The consultant led team is well supported by a team of dental nurses and technicians. The team provide outpatients consultations, advice and procedures.
	Pain	The Bradford pain management team provide an experienced and

	Management Centre	specialised approach to the treatment of chronic pain. The team provide outpatient consultation, advice and treatment. They work closely with Musculoskeletal (MSK) service.
	Psychology	The psychology service provides consultation and treatment support to many specialties through a referral system for inpatient and outpatient care. This includes adult and child psychology providing a holistic experience for patients.

(Source: Routine Provider Information Request (RPIR) – P2. Sites tab)

Total number of first and follow up outpatient attendances compared to England

The trust had 432,092 first and follow up outpatient attendances from March 2018 to February 2019. The graph below represents how this compares to other trusts:



(Source: Hospital Episode Statistics - HES Outpatients)

Number of appointments by site

The following table shows the number of outpatient appointments by site, a total for the trust and the total for England, from March 2018 to February 2019:

Site Name	Number of appointments

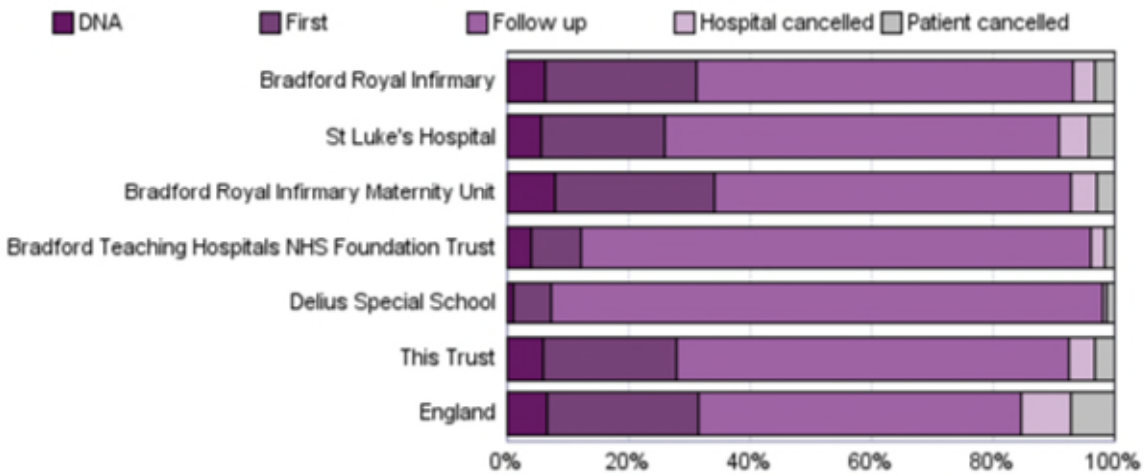
Bradford Royal Infirmary	213,657
St Luke's Hospital	197,781
Bradford Royal Infirmary Maternity Unit	48,515
Bradford Teaching Hospitals NHS Foundation Trust	22,011
Delius Special School	13,280
This Trust	499,616
England	109,324,322

(Source: Hospital Episode Statistics)

Type of appointments

The chart below shows the percentage breakdown of the type of outpatient appointments from March 2018 to February 2019. The percentage of these appointments by type can be found in the chart below:

Number of appointments at Bradford Teaching Hospitals NHS Foundation Trust from March 2018 to February 2019 by site and type of appointment



(Source: Hospital Episode Statistics)

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.
*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure most completed it.

Mandatory training completion rates

The trust set two different targets of 85% and 95% for completion of mandatory training. These targets were dependant on individual modules.

Trust level outpatient departments

A breakdown of compliance for mandatory training courses April 2018 to March 2019 at trust level for qualified nursing staff in outpatients is shown below:

Training module name	April 2018 to March 2019				
	Eligible staff	Staff trained	Completion rate	Trust target	Met (Yes/No)
Mental Capacity Act Level 2	14	14	100.0%	85%	Yes
Communication Improvement using the SBAR Technique General	14	14	100.0%	85%	Yes
Venous Thromboembolism - No Renewal	12	12	100.0%	85%	Yes
Mental Capacity Act Level 1	14	14	100.0%	85%	Yes
Corporate Induction	14	14	100.0%	85%	Yes
Infection Control - No Renewal	14	14	100.0%	85%	Yes
Introduction to Equality & Diversity General	14	14	100.0%	85%	Yes
Adult Basic Life Support - 1 Year	14	12	85.7%	85%	Yes
Diabetes Care and Safe Use of Insulin General	12	10	83.3%	85%	No
Information Governance - 1 Year	14	11	78.6%	95%	No
Safe Administration of Medicines - 2 Year	12	8	66.7%	85%	No
Infection Control - 1 Year	14	9	64.3%	85%	No
Conflict Resolution - 3 Years	14	8	57.1%	85%	No
Moving & Handling Medium/High Risk General	14	6	42.9%	85%	No

In outpatients, the 95% target was not met for the single applicable module and the 85% target was met for eight of the remaining 13 mandatory training modules for which qualified nursing staff were eligible.

The trust reported that there were no applicable medical staff at the trust for outpatients.

St Luke's Hospital outpatient department

A breakdown of compliance for mandatory training courses April 2018 to March 2019 at St Luke's Hospital for qualified nursing staff in outpatients is shown below:

Training module name	April 2018 to March 2019				
	Eligible staff	Staff trained	Completion rate	Trust target	Met (Yes/No)
Mental Capacity Act Level 2	8	8	100.0%	85%	Yes
Mental Capacity Act Level 1	8	8	100.0%	85%	Yes
Corporate Induction	8	8	100.0%	85%	Yes
Infection Control - No Renewal	8	8	100.0%	85%	Yes

Venous Thromboembolism - No Renewal	8	8	100.0%	85%	Yes
Introduction to Equality & Diversity General	8	8	100.0%	85%	Yes
Communication Improvement using the SBAR Technique General	8	8	100.0%	85%	Yes
Diabetes Care and Safe Use of Insulin General	8	7	87.5%	85%	Yes
Information Governance - 1 Year	8	7	87.5%	95%	No
Safe Administration of Medicines - 2 Year	8	6	75.0%	85%	No
Infection Control - 1 Year	8	6	75.0%	85%	No
Adult Basic Life Support - 1 Year	8	6	75.0%	85%	No
Moving & Handling Medium/High Risk General	8	4	50.0%	85%	No
Conflict Resolution - 3 Years	8	4	50.0%	85%	No

In outpatients, the 95% target was not met for single applicable module and the 85% target was met for eight of the remaining 14 mandatory training modules for which qualified nursing staff were eligible.

The trust reported that there were no applicable medical staff at the trust for outpatients.

The mandatory training was comprehensive and met the needs of patients and staff. Staff we spoke with explained training was delivered as e-learning with face to face practical sessions where appropriate, such as basic life support.

Sepsis training was not mandatory, however staff we spoke with could explain signs and symptoms of sepsis. One staff member we spoke with told us they completed sepsis training on line.

Managers monitored mandatory training and alerted staff via email when they needed to update their training. For example, we saw all staff had a training matrix. Completed modules were labelled green, those due were amber and those overdue were red.

Staff we spoke with demonstrated how they accessed the electronic system to book their training on-line. All staff and managers we spoke with told us they were on trajectory to reach 100% compliance by the end of the year (March 2020). They completed a summary training compliance template each month for clinical governance meetings.

Staff we spoke with confirmed they usually had protected time to complete their training although on occasion, training was cancelled due to staffing requirements in the department.

Safeguarding

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

Safeguarding training completion rates

The trust set a target of 85% for completion of safeguarding training.

Trust level outpatient department

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 at

trust level for qualified nursing staff in outpatients is shown below:

Training module name	April 2018 to March 2019				
	Eligible staff	Staff trained	Completion rate	Trust target	Met (Yes/No)
Safeguarding Children Level 1 - 3 Years	14	14	100.0%	85%	Yes
Safeguarding Adults Level 2 - 3 Years	14	14	100.0%	85%	Yes
Safeguarding Children Level 2 - 3 Years	14	13	92.9%	85%	Yes
Safeguarding Adults Level 1 - 3 Years	14	13	92.9%	85%	Yes

In outpatients, the 85% target was met for all safeguarding training modules for which qualified nursing staff were eligible.

The trust reported that there were no applicable medical staff at the trust for outpatients.

St Luke's Hospital outpatient department

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 at St Luke's Hospital for qualified nursing staff in outpatients is shown below:

Training module name	April 2018 to March 2019				
	Eligible staff	Staff trained	Completion rate	Trust target	Met (Yes/No)
Safeguarding Children Level 2 - 3 Years	8	8	100.0%	85%	Yes
Safeguarding Children Level 1 - 3 Years	8	8	100.0%	85%	Yes
Safeguarding Adults Level 1 - 3 Years	8	8	100.0%	85%	Yes
Safeguarding Adults Level 2 - 3 Years	8	8	100.0%	85%	Yes

In outpatients, the 85% target was met for all safeguarding training modules for which qualified nursing staff were eligible.

The trust reported that there were no applicable medical staff at the trust for outpatients.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Nursing staff received training specific for their role and they could describe different types of abuse.

We saw staff accessed safeguarding policies on the trust intranet. Staff accessed guidance regarding abuse such as female genital mutilation (FGM). FGM is defined by the World Health Organisation as 'procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons.'

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. For example, we saw how staff reviewed GP referrals. Reception staff we spoke with demonstrated how flags were put on the electronic patient record to identify children looked after, those on child protection plans and vulnerable adults.

In addition, we saw there was an information sharing agreement in place with the local authority regarding a list of high-risk victims of child sexual exploitation (CSE). Staff we spoke with told us a flag was placed on their electronic patient record to alert staff.

There was a policy in place for children and adults that did not attend (DNA) their appointments. Patients that DNA had a flag placed on their electronic record, GPs were informed and staff in the service followed up with a phone call to the patient.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff we spoke with identified the safeguarding lead and gave specific examples of safeguarding concerns they had raised. They described the reporting and documentation process they followed, which was in accordance with trust safeguarding policy.

We saw posters and leaflets to signpost patients and visitors to access help, for example, domestic and sexual abuse.

We observed chaperone posters in the departments we visited. Patients undergoing intimate examinations were always offered a chaperone and we saw this documented in the electronic patient records.

Cleanliness, infection control and hygiene

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

All consumable items we checked in the areas we visited were within expiry dates.

Clinical areas were clean and most had suitable furnishings which were clean and well-maintained. The exceptions were in some clinical areas where we saw fabric curtains and upholstered seating which was not impermeable. However, these appeared visibly clean and in good order. Staff explained the curtains were changed by domestic staff every six months as a minimum and records were held by the domestic supervisors. We did not view these records.

There were some designated waiting areas for patients with children. These areas were clean and toys were clean.

All clinical hand wash basins were compliant with infection prevention and control best practice guidance. There were hand washing posters displayed above each basin.

Clean and dirty utility rooms we inspected were clean and tidy.

The service generally performed well for cleanliness in local hand hygiene audits and environmental spot-checks. Although all areas we inspected were visibly clean, the data provided by the trust indicated 65% compliance with completion of nursing daily cleaning checklists. However, the cleaning records we reviewed at the hospital were completed well.

Staff followed infection control principles including the use of personal protective equipment (PPE). For example, all staff we saw complied with ‘bare arms below the elbows’ policy. We observed all staff washed their hands and used sanitising gel between each patient contact and when entering and exiting clinical areas.

Staff had access to non-latex gloves and aprons available in dispensers in all clinical areas.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. For example, we saw dated ‘I am clean’ labels in use on vital signs monitoring equipment and the resuscitation equipment trolley.

Staff we spoke with explained patients with known potentially infectious conditions such as methicillin resistant staphylococcus aureus (MRSA), were given appointments at the end of clinic and domestic staff conducted a deep clean when required.

Domestic staff worked outside of clinic hours, to minimise disruption. We saw domestic equipment was locked away when not in use.

We saw biohazard kits available to manage spillages of blood and body fluids.

Managers we spoke with told us there was high uptake of the influenza vaccine by staff working in the service.

Environment and equipment

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

Patient led assessments of the care environment (PLACE) showed that the outpatients department at this trust scored 89.9% for condition, appearance and maintenance, compared to the national average of 94.3%.

Patient led assessments of the care environment (PLACE) regarding how well the needs of a patient living with a disability were met, showed that that this trust scored 75.6% compared to the national average of 84.2%.

Assisted access toilets and all clinic rooms had emergency call bells.

Staff carried out daily safety checks of specialist equipment when the department was open, in accordance with local policy. We reviewed the checking records for the hypoglycaemia box and resuscitation equipment and found no gaps. The resuscitation equipment trolley had a tamper proof tag with a unique number which was recorded at each check.

The service had suitable facilities to meet the needs of patients and families. For example, in waiting areas we saw variable height seating, smaller seating for children and bariatric seating.

Staff we spoke with told us the phlebotomy clinic often became very busy and they used a numbered ticket system to call patients in order. Managers we spoke with explained they were considering options for developing the phlebotomy services to improve patient experience.

We observed the environmental décor and signage to be dementia friendly. Each area was colour coded to support sensory stimulation and ensure people living with dementia could navigate the department more easily.

The service had enough suitable equipment to help them to safely care for patients. Weigh scales we checked had all been calibrated within the last 12 months.

Access to dirty and clean utility rooms was restricted. Staff disposed of clinical waste safely. All areas we inspected had pedal operated waste bins which contained the correct liner for the waste stream. All sharps disposal bins we inspected were assembled and labelled correctly and stored off the floor.

Fire exits were clear of obstructions and all fire extinguishers we checked were signposted and had been tested.

Assessing and responding to patient risk

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

Staff responded promptly to any sudden deterioration in a patient's health. For example, all staff we spoke with were aware how to raise the alarm and raise a cardiac arrest call by dialling 2222. Staff we spoke with told us if they needed help with a situation called switchboard for the crisis team or security.

Specialist nurses gave patients their contact details, so they could escalate any change in condition or seek advice when they needed to.

A policy was in place to manage patients that did not attend their appointment.

Staff we spoke with explained they contacted the mental health team if they had concerns about patients requiring mental health support or those living with learning difficulties. We observed information about individual patient needs, documented in the electronic patient records.

Shift changes and handovers included all necessary key information to keep patients safe. This was shared in daily 08.45 safety huddles.

The management team we spoke with told us clinical staff validated waiting lists, prioritised patients for review and discharged patients where appropriate. Alongside this, administrative staff reviewed waiting lists to cleanse data. This ensured patients not requiring follow up were removed. We saw a written procedure in place to support this.

Specialties that conducted invasive procedures within outpatients, used world health organisation safety checklists and compliance with completion was audited. The results indicated high compliance.

Staffing

Nurse staffing

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

Managers we spoke with explained nurses and health care assistants worked flexibly across clinics and across hospital sites in most specialties. However, some staff worked consistently in the same clinics. For example, maxillofacial and dermatology clinics.

Outpatient managers explained they did not use a nurse staffing tool to calculate staffing levels but managed nurse and health care assistant staffing levels depending on which clinics were running each day.

Staffing was planned in advance with individual specialties and was flexible to meet the clinic needs. There was always staff allocated to cover after 5pm in the event clinics overran.

Managers booked bank and agency staff that were familiar with the service, as required. We saw detailed department-specific induction documentation for these staff on file.

Staff we spoke with told us staffing levels always felt safe and patients we spoke with told us they felt staffing levels to be adequate.

We observed that planned and actual staffing numbers displayed in clinics. In each of the areas we visited, planned and actual levels matched, on the day of inspection.

Staff we spoke with said they felt supported by their consultant colleagues.

Trust level

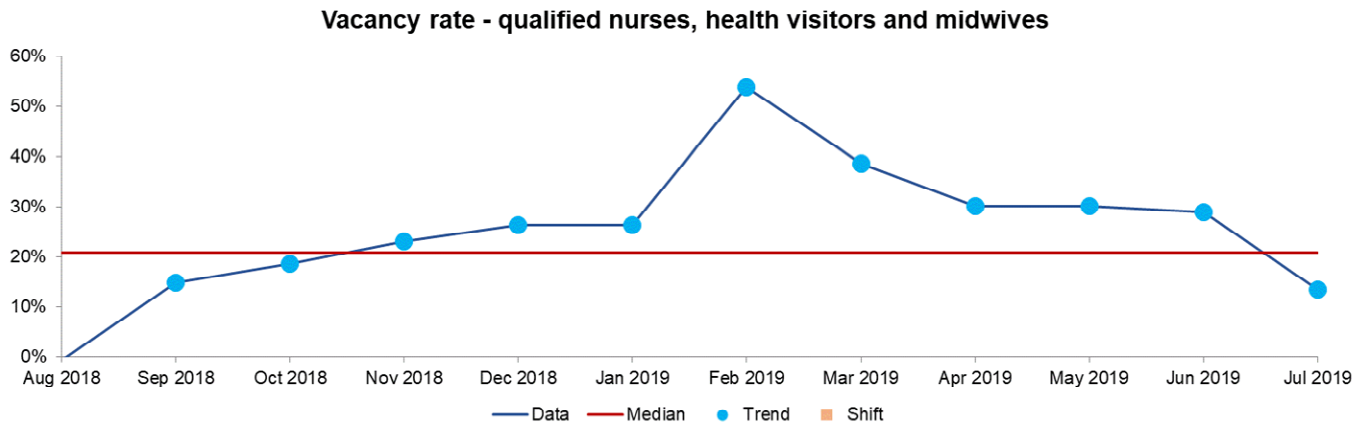
The table below shows a summary of the nursing staffing metrics in outpatients at trust level compared to the trust's targets, where applicable:

	Outpatients annual staffing metrics August 2018 to July 2019						
Staff group	**Annual average establishment**	**Annual vacancy rate**	**Annual turnover rate**	**Annual sickness rate**	**Annual bank hours (% of available hours)**	**Annual agency hours (% of available hours)**	**Annual unfilled hours (% of available hours)**
Target		N/A	N/A	4.5%			
All staff	529.4	6.8%	9.4%	4.6%			
Qualified nurses	20.0	23.7%	8.6%	5.3%	4,972 (4%)	1,589 (1%)	2,004 (2%)

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing bank agency tabs)

Nurse staffing rates within outpatients were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover, bank or agency use.

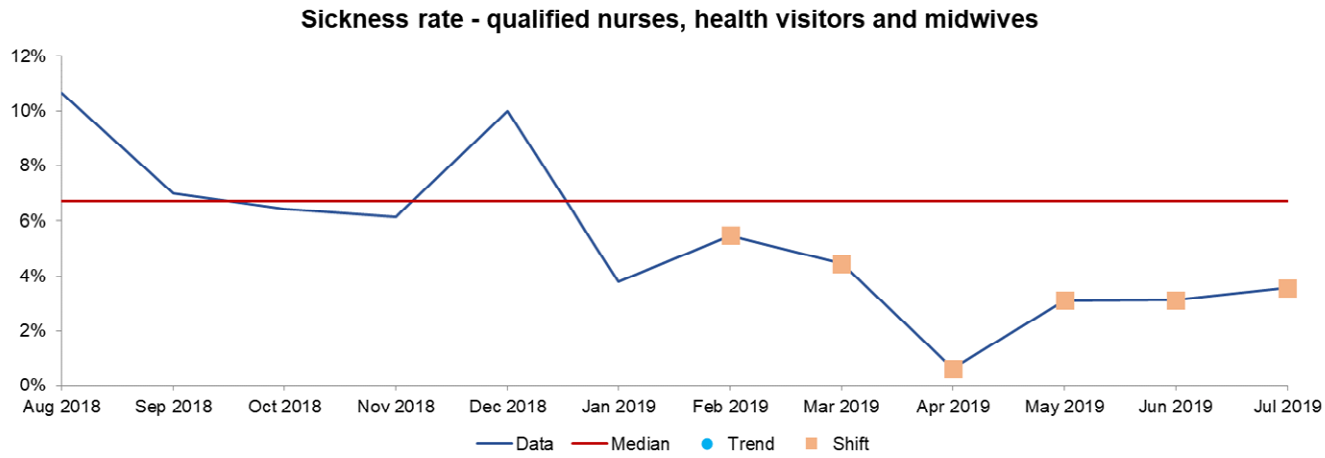
Vacancy rates



Monthly vacancy rates over the last 12 months for qualified nurses, health visitors and midwives shows a downward trend from February 2019 to July 2019. This could be an early indicator of improvement.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Sickness rates



Monthly sickness rates over the last 12 months for qualified nurses, health visitors and midwives shows a shift from February 2019 to July 2019. This could be an indicator of change.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

St Luke's Hospital

The table below shows a summary of the nursing staffing metrics in outpatients at St Luke's Hospital compared to the trust's targets, where applicable:

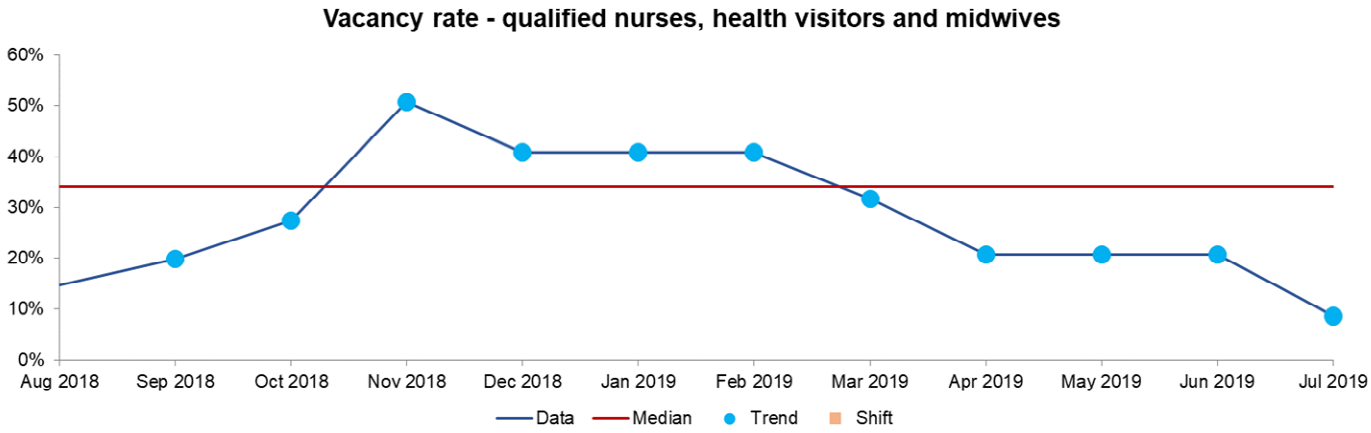
	Outpatients annual staffing metrics						
	August 2018 to July 2019						
Staff group	**Annual average establishment**	**Annual vacancy rate**	**Annual turnover rate**	**Annual sickness rate**	**Annual bank hours (% of available hours)**	**Annual agency hours (% of available hours)**	**Annual unfilled hours (% of available hours)**
Target		N/A	N/A	4.5%			
All staff	152.1	12.0%	10.1%	5.0%			
Qualified nurses	12.0	27.2%	0.0%	4.4%	N/A*	N/A*	N/A*

NOTE*: The trust was unable to specify their bank and agency usage at site level.

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing Bank Agency tabs)

Nurse staffing rates within outpatients at St Luke's Hospital were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover or sickness. (The trust was unable to specify their bank and agency usage at site level.)

Vacancy rates



Monthly vacancy rates over the last 12 months for qualified nurses, health visitors and midwives shows a downward trend from November 2018 to July 2019. This could be an early indicator of improvement.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Medical staffing

The trust reported that there were no applicable medical staff at the trust for outpatients.

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)

Allied health professional staffing

Trust level

The table below shows a summary of the allied health professional staffing metrics in outpatients at trust level compared to the trust's targets, where applicable:

	Outpatients annual staffing metrics						
	August 2018 to July 2019						
Staff group	**Annual average establishment**	**Annual vacancy rate**	**Annual turnover rate**	**Annual sickness rate**	**Annual bank hours (% of available hours)**	**Annual locum hours (% of available hours)**	**Annual unfilled hours (% of available hours)**
Target		N/A	N/A	4.5%			
All staff	529.4	6.8%	9.4%	4.6%			
Allied health professionals	176.1	0.7%	N/A*	2.1%			

NOTE*: The trust did not submit turnover data for AHP's.

Note that all allied health professionals within outpatients at the trust are located at Bradford Royal Infirmary.

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)

Records

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

Patient notes were comprehensive. Most patient records, including referral letters and all diagnostic results were electronic. A small number of patients requiring follow up still had paper records. Staff we spoke with explained these were retrieved in advance to ensure they were always available for clinic.

Staff used a smart card and individual password to access them and ensure security.

Staff we spoke with explained the outpatient service did not conduct audits of the electronic records, although the management team was aware there were some data quality issues. However, we inspected five electronic records. All were detailed and completed comprehensively.

Staff we spoke with told us the system did not allow closure of records without generating a summary letter to the referrer. These letters were dictated by consultants and sent electronically or by post.

Medicines

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

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. For example, staff we spoke with explained medicines alerts were discussed as part of the daily safety huddles.

Staff had access to British national formulary on-line. Hard copies we saw were the most recent edition.

Staff stored and managed medicines in line with the provider's policy.

All medicines were prescribed by consultants or non-medical prescribers.

Minimal stocks of medicines were held in the service. No controlled drugs (CD) were stored in the areas we inspected.

Prescription forms specifically for outpatients were kept securely.

Staff had access to emergency medicines in the event of reactions or anaphylaxis.

Medicines were stored in locked cupboards and refrigerators. Medicines we checked in the areas we visited were within expiry dates. Staff we spoke with explained the department stocks were replenished weekly from Bradford pharmacy. Staff received support from a pharmacist when required.

Medicine refrigerator temperature checks were recorded during clinic opening times, in accordance with local policy.

Some trained nurses in the service were also non-medical prescribers, (NMP's). NMP's attended twice yearly meetings and were supervised by consultants. There was also a named NMP lead in post. Non-medical prescribing was audited annually.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately.

Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them, in line with trust policy. For example, staff we spoke with said us the trust advocated a no-blame, positive reporting culture and described specific examples of incidents they had reported.

They explained learning from incidents and national safety alerts was shared at the daily 08.45 safety huddles and more widely via 'learning matters' bulletin and email rapid response bulletins from the risk management team.

Staff were aware of national patient safety alerts. However, staff we spoke with were unable to tell us about changes to practice following alerts.

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From August 2018 to July 2019, the trust did not report and never events for outpatients.

(Source: Strategic Executive Information System (STEIS))

Staff we spoke with were not aware of any never events that had happened anywhere else within the trust.

Breakdown of serious incidents reported to STEIS

Trust level

In accordance with the Serious Incident Framework 2015, the trust did not report any serious incidents (SIs) in outpatients which met the reporting criteria set by NHS England from August 2018 to July 2019.

(Source: Strategic Executive Information System (STEIS))

Staff understood the duty of candour. 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. This regulation requires staff to be open, transparent and candid with patients and relatives when things go wrong. Local policy and national documents relating to duty of candour were available via the trust intranet. Staff we spoke with were aware of the need to be open and honest when something went wrong.

Safety thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

Formal safety thermometer reporting was not used in outpatients. However, they did record and display local results of dress code and hand hygiene audits. Compliance was high.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice.

Staff followed up-to-date policies and guidance to plan and deliver high quality care according to best practice and national guidance. For example, policies we saw were referenced to best practice guidance and managers we spoke with explained clinical specialty guidance was reviewed every two years. The governance manager kept a tracker of national institute for health and care excellent (NICE) guidance and communicated it out via a virtual guidelines group.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health.

There was drinking water available for patients in the outpatient area waiting areas we visited.

Information about patient nutritional and hydration status was communicated to outpatients in GP referral letters and was available to staff in the electronic patient record.

Staff we spoke with told us they could request food and drinks from catering services for patients with diabetes or those waiting for hospital transport. In addition, there were tea bars run by hospital volunteers where patients and visitors could purchase drinks and snacks.

Staff we spoke with told us they could arrange support from dieticians and speech and language therapists for patients who may need their input to improve their nutrition and hydration.

Pain relief

Staff assessed patients to see if they were in pain and gave pain relief in a timely way.

We observed a rheumatology clinic and saw staff assessed a patient's pain by asking them directly, how they were coping with their pain. The patient indicated they were taking their medications and pain was well controlled.

There was a small stock of oral analgesia available in the department which staff gave as prescribed, if required.

Physiotherapy department had a hydrotherapy pool. Staff we spoke with explained this was used to improve joint flexibility and help relieve pain in rheumatology patients.

Patient outcomes

Staff monitored the effectiveness of care and treatment.

National audit activities were completed by the overarching clinical specialities, and outcomes were shared with out-patient teams. For example, national early inflammatory arthritis audit.

Recommended actions were implemented where appropriate.

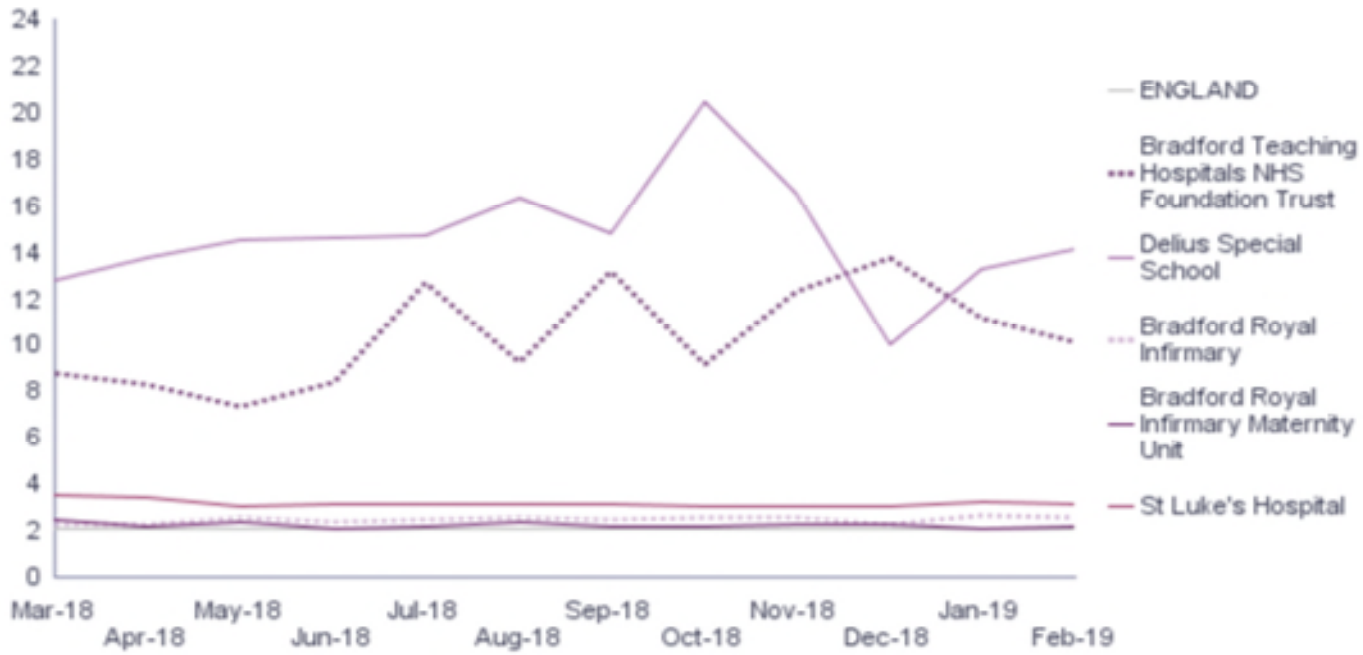
Staff we spoke with told us they participated in local hand hygiene audits, dresscode audits and departmental cleanliness audits. We reviewed the results for September to November 2019 and all areas in outpatients exceeded their target compliance rates.

Follow-up to new rate

From March 2018 to February 2019 the following follow up rates by site are compared to the England average:

- Bradford Teaching Hospitals NHS Foundation Trust was higher than the England average.
- Bradford Royal Infirmary was slightly higher than the England average.
- St Luke's Hospital was slightly higher than the England average.
- Bradford Royal Infirmary maternity unit was similar to the England average.
- Delius Special School was higher than the England average.

Follow-up to new rate, Bradford Teaching Hospitals NHS Foundation Trust.



(Source: Hospital Episode Statistics)

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Staff we spoke with told us they received clinical supervision from band six and band seven nursing colleagues.

Non-medical prescribers we spoke with explained they attended non-medical prescriber updates twice a year and received supervision from named consultants. There was also a NMP lead in post.

Staff we spoke with explained they received competency training in specialist skills. Consultants provided this training within the department and signed staff off when competent.

All health care assistants were required to complete a 'care certificate' training programme during their probationary period, covering all competencies required for their role.

Managers gave all new staff a full induction tailored to their role before they started work. We saw induction records within the department.

Appraisal rates

Managers supported staff to develop through yearly, constructive appraisals of their work.

From August 2018 to July 2019 92.1% of staff within outpatients department at the trust received an appraisal. The trust target was 95% to December each year.

The breakdown by staff group can be seen in the table below:

Trust level

Staff group	August 2018 to July 2019				
	Staff who received an appraisal	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Healthcare Scientists	20	20	100.0%	95%	Yes
Add Prof Scientific and Technic	2	2	100.0%	95%	Yes
Estates and Ancillary	1	1	100.0%	95%	Yes
Nursing and Midwifery Registered	56	57	98.2%	95%	Yes
Allied Health Professionals	47	49	95.9%	95%	Yes
Administrative and Clerical	127	135	94.1%	95%	No
Additional Clinical Services	61	77	79.2%	95%	No

Please interpret completion rates with care where small numbers of staff are involved.

St Luke's Hospital outpatient department

Staff group	August 2018 to July 2019				
	Staff who received an appraisal	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Add Prof Scientific and Technic	1	1	100.0%	95%	Yes
Nursing and Midwifery Registered	23	23	100.0%	95%	Yes
Allied Health Professionals	46	47	97.9%	95%	Yes
Administrative and Clerical	110	116	94.8%	95%	No
Additional Clinical Services	29	34	85.3%	95%	No

Please interpret completion rates with care where small numbers of staff are involved.

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

Multidisciplinary working

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

Staff held regular and effective multidisciplinary team (MDT) meetings to discuss patients and improve their care. Staff such as a rheumatology specific physiotherapist and specialist nurses attended these weekly meetings.

Seven-day services

Outpatient services were not available seven days a week.

Most out-patients clinics operated between 08.30 – 17.30 from Monday to Friday. There were no routine evening clinics at this hospital.

Staff called for support from doctors and other disciplines, during outpatient operational hours. For example, specialist dieticians, psychologists, mental health services and diagnostic tests.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support in patient areas. For example, there were posters and leaflets about smoking cessation, alcohol consumption management, mental health and wellbeing, dementia awareness, support for carers and relatives, condition-specific leaflets and medicine information leaflets.

People were involved in monitoring their own health, including health assessments and checks, where appropriate and necessary. For example, patients we spoke with that were living with long term conditions, told us that staff worked with them to increase their understanding of their condition. This enabled them to identify if their condition was changing. If so, they were encouraged to contact the service directly to access an earlier appointment than their planned routine follow up.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.

They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

We observed staff gained consent from patients for care and treatment, using simple terminology, in accordance with legislation and best practice guidance.

Staff clearly recorded consent in the patients' records.

Mental Capacity Act and Deprivation of Liberty Safeguards training completion

Nursing staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

Trust level

The trust set a target of 85% for completion of Mental Capacity Act (MCA) training.

The trust did not supply training data regarding DOLS training modules.

A breakdown of compliance for MCA training modules from April 2018 to March 2019 at trust level for qualified nursing staff in outpatients is shown below:

Training module name	April 2018 to March 2019				
	Eligible staff	Staff trained	Completion rate	Trust target	Met (Yes/No)
Mental Capacity Act Level 2	14	14	100.0%	85%	Yes
Mental Capacity Act Level 1	14	14	100.0%	85%	Yes

In outpatients the target was met for all the MCA training modules for which qualified nursing staff were eligible.

The trust reported that there were no applicable medical staff at the trust for outpatients.

St Luke's Hospital outpatient department

The trust set a target of 85% for completion of Mental Capacity Act (MCA) training.

A breakdown of compliance for MCA training modules from April 2018 to March 2019 at St Luke's Hospital for qualified nursing staff in outpatients is shown below:

Training module name	April 2018 to March 2019				
	Eligible staff	Staff trained	Completion rate	Trust target	Met (Yes/No)
Mental Capacity Act Level 2	8	8	100.0%	85%	Yes
Mental Capacity Act Level 1	8	8	100.0%	85%	Yes

In outpatients the target was met for all of the MCA training modules for which qualified nursing staff were eligible.

The trust reported that there were no applicable medical staff at the trust for outpatients.

Shipley Hospital outpatients department

(Source: Routine Provider Information Request (RPIR) – Training tab)

Is the service caring?

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

All patients we spoke with told us staff treated them with respect and maintained their dignity and privacy. For example, by ensuring clinic doors were closed during appointments, using curtains in treatment rooms, and asking how they liked to be addressed.

Waiting areas were situated away from reception desks. This meant when reception staff spoke with patients, their privacy and confidentiality were protected as far as possible.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Staff we spoke with told us that gender specific chaperones were available and provided as necessary. We saw this was recorded in individual patient records. Staff accessed information about the responsibilities of chaperones in the dignity and respect trust policy. However, staff we spoke with explained they did not receive formal chaperone training.

Staff described situations when they identified patients who may have mental health needs and the steps they took to ensure patients were safe, while maintaining their dignity.

All patients we spoke with gave positive feedback about the care they received. The friends and family test (FFT) results for outpatients at this trust showed that in October 2019, 97% of respondents were extremely likely or likely to recommend the service.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it.

Specialist nurses provided care and support for patients. We saw patients were offered contact details, so they could call specialist nurses if they had any questions or concerns.

They also signposted patients to other charitable support networks in the locality. Staff referred patients to psychologists at the trust if required.

There was a quiet room available with seating, for patients to use if they were anxious or worried when visiting the department. Staff we spoke with explained they also used it for private discussion with patients and to provide privacy if they were distressed.

Staff we spoke with understood how to support patients who may need additional support, for example, patients living with dementia, learning disabilities or vulnerable adults.

Staff described how they adapted to the needs of patients. For example, they provided separate waiting areas for distressed or anxious patients, and fast- tracked those that were anxious or phobic, living with dementia or learning disabilities.

We saw leaflets available which addressed issues associated with patient diagnosis, such as anxiety, changes in physical appearance, carer or relative support and financial concerns.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. During the inspection, patients told us staff explained things to them clearly and involved them in making decisions about their care and treatment. We saw patients were given the choice of bringing a relative or friend with them to their appointments. Patients and family members we spoke with told us they felt included and involved during consultations.

Staff ensured there was an interpreter at appointments if necessary so patients and their relatives could understand everything during their consultation and staff we spoke with told us that the service was easy to access.

Patients we spoke with described receiving copies of letters sent between the hospital and their GP if they had requested this.

There was a wide range of patient information leaflets available throughout clinics providing information about a variety of health conditions.

Is the service responsive?

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served.

Clinics were provided during core hours only.

Waiting lists were held by each speciality and the method of care delivery was face to face.

The service minimised the number of times patients needed to attend the hospital. Some patients had access to the required staff and tests at one- stop clinics. For example, rheumatology clinic where patients received a scan, injections if required and physiotherapy.

The service had systems to help care for patients in need of additional support or specialist intervention.

Managers ensured that patients who did not attend appointments were contacted, in accordance with local policy.

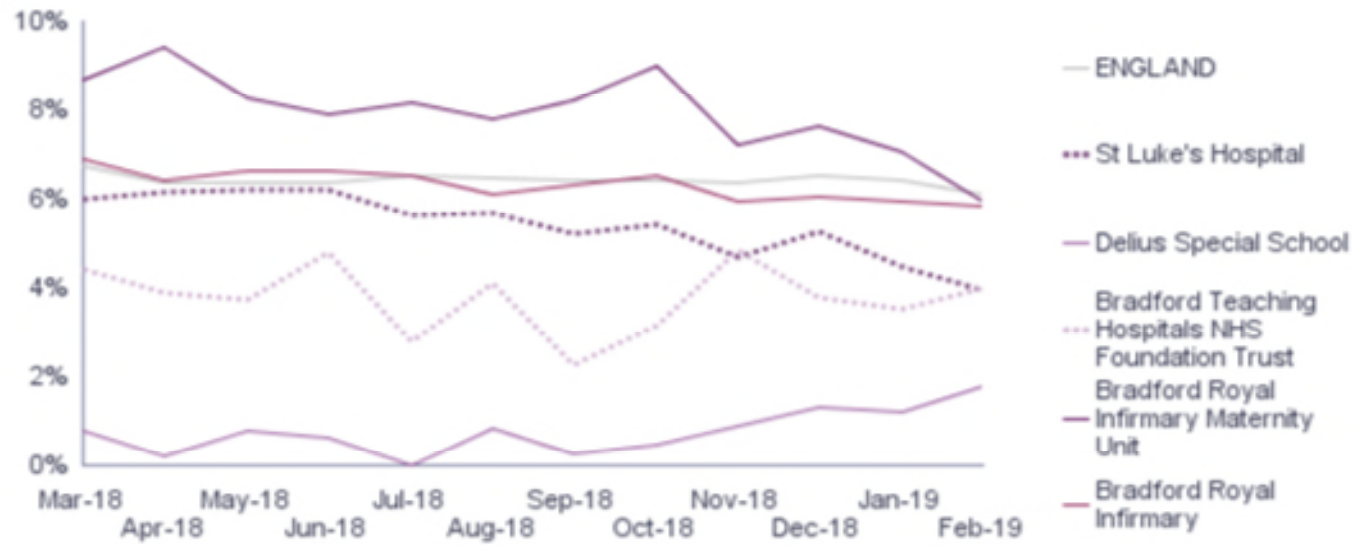
Did not attend rate

From March 2018 to February 2019 the following 'did not attend' rates per site can be compared:

- Bradford Teaching Hospitals NHS Foundation Trust was lower than the England average.
- Bradford Royal Infirmary was similar to the England average.
- St Luke's Hospital was lower than the England average.
- Delius Special School was lower than the England average.
- Bradford Royal Infirmary maternity unit was higher than the England average.

The chart below shows the 'did not attend' rate over time:

Proportion of patients who did not attend appointment, Bradford Teaching Hospitals NHS Foundation Trust



(Source: Hospital Episode Statistics)

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.

They coordinated care with other services and providers.

Staff made sure patients received the necessary care to meet all their needs. For example, staff we spoke with described how they ensured patients living with learning difficulties were given appointment times to minimise disruption the their usual routines.

Clinics were designed to meet the needs of patients living with dementia. For example, Staff supported patients living with dementia and learning disabilities by using 'this is me' documents and patient passports. Patients that had these documents were flagged on their electronic patient record.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Reception areas we saw, had a hearing loop system installed.

Staff we spoke with understood the local demographic and had access to information leaflets available in languages spoken by the patients and local community. In addition, we noted flags on the electronic patient record if an interpreter was required. Interpreters usually attended in person, but staff could also access interpreters on line and by telephone.

Access and flow

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

The referral to treatment time (RTT) data for December 2019 showed the trust was at 88% against a target of 92%. RTT and associated action plans were discussed routinely in the clinical business unit governance meetings and this was minuted.

Managers monitored waiting times and made sure patients could access services when needed. For example, there was a fast track system which ensured patients with possible cancer diagnosis were seen within two weeks of referral. Patients were triaged by staff in central bookings and a specialty consultant. Managers we spoke with told us the service was currently meeting their two-week wait target.

We observed waiting areas and noted sufficient flow. No patients were standing while waiting. Staff we spoke with explained if clinics were delayed by 20 minutes, they apologised and made waiting patients aware of the reason for the delays.

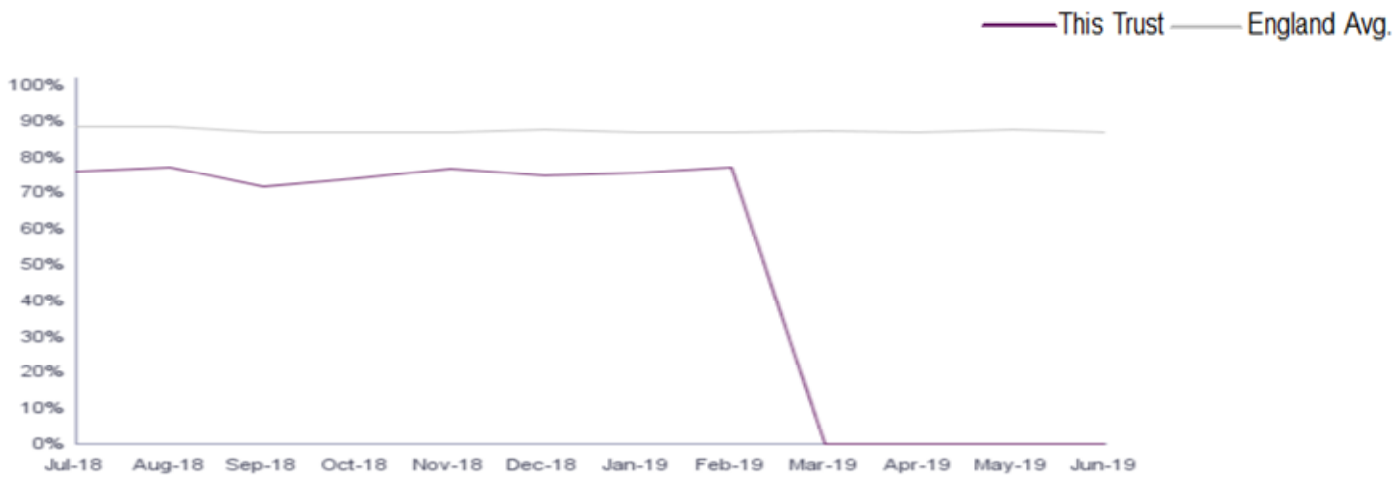
Outpatient appointment bookings were managed centrally. However, staff could also book patients into rapid access to clinics where required.

Managers monitored cancellations of clinics. We reviewed data for September to November 2019 and saw the rate for cancellations under six weeks was 1.65%. Cancellations over six weeks were 2.72%. The main reason was staff annual leave.

Referral to treatment (percentage within 18 weeks) – non-admitted pathways

From July 2018 to February 2019, the trust's referral to treatment (RTT) time for non-admitted pathways fluctuated. From March 2019 the trust has not submitted any non-admitted RTT data nationally (although incomplete pathway data has been submitted during this period).

Referral to treatment rates (percentage within 18 weeks) for non-admitted pathways, Bradford Teaching Hospitals NHS Foundation Trust



(Source: NHS England)

Referral to treatment (percentage within 18 weeks) non-admitted performance – by specialty

The following specialty was above the England average for non-admitted pathways RTT (percentage within 18 weeks):

Specialty grouping	Result	England average
Geriatric Medicine	99.4%	94.9%

The following sixteen specialties were below the England average for non-admitted pathways RTT (percentage within 18 weeks):

Specialty grouping	Result	England average
Gynaecology	84.1%	90.8%
Dermatology	83.5%	87.6%
General Medicine	82.6%	90.9%
Other	81.0%	89.6%
Oral Surgery	79.8%	79.9%
Ophthalmology	75.2%	88.4%
Rheumatology	74.7%	85.6%
Trauma & Orthopaedics	74.0%	85.5%
Plastic Surgery	70.8%	90.1%
Urology	70.1%	84.1%
Thoracic Medicine	67.1%	85.9%
Cardiology	64.4%	85.2%
Gastroenterology	61.3%	80.7%

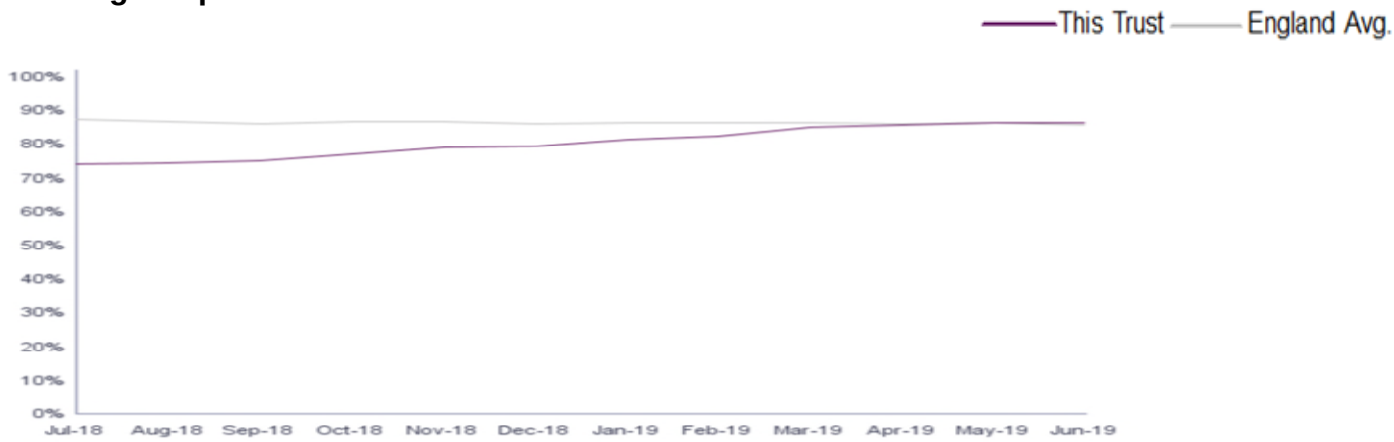
Ear, Nose & Throat (ENT)	57.0%	83.3%
General Surgery	51.9%	88.3%
Neurology	51.2%	77.0%

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – incomplete pathways

From July 2018 to April 2019 the trust's referral to treatment time (RTT) for incomplete pathways has been worse for each month than the England overall performance. The overall trajectory has been improving and in April 2019 the trust achieved the same performance (86.4%) as the England average. Subsequently, in June 2019 was trust (86.4%) was slightly higher than the England average (85.8%).

Referral to treatment rates (percentage within 18 weeks) for incomplete pathways, Bradford Teaching Hospitals NHS Foundation Trust.



(Source: NHS England)

Referral to treatment (percentage within 18 weeks) incomplete pathways – by specialty

Three specialties were above the England average for incomplete pathways RTT (percentage within 18 weeks):

Specialty grouping	Result	England average
Geriatric Medicine	99.4%	95.8%
Oral Surgery	85.8%	82.0%
Trauma & Orthopaedics	82.5%	81.3%

Fourteen specialties were below the England average for incomplete pathways RTT (percentage within 18 weeks):

Specialty grouping	Result	England average
Gynaecology	87.3%	87.5%
General Medicine	85.1%	91.2%
Cardiology	83.1%	89.3%
Other	82.7%	88.8%
Rheumatology	82.1%	90.8%
Dermatology	81.6%	89.3%
Urology	79.7%	84.6%
Ophthalmology	79.1%	86.2%
Gastroenterology	78.8%	87.7%
Plastic Surgery	78.8%	82.2%

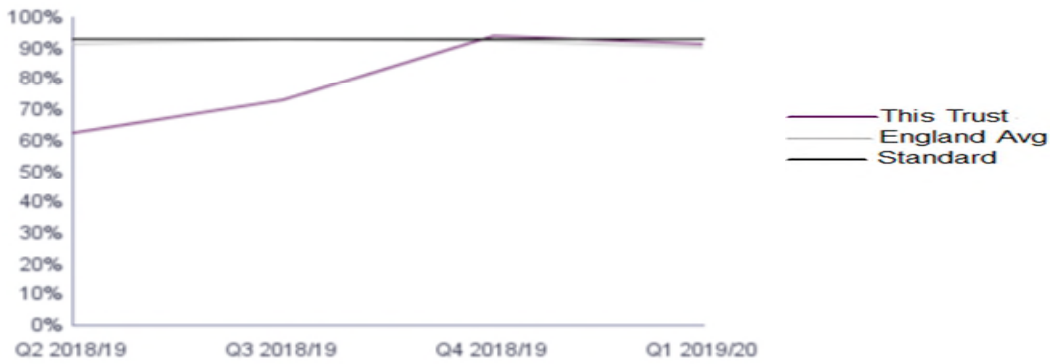
Neurology	77.8%	86.2%
Thoracic Medicine	77.6%	89.2%
Ear, Nose & Throat (ENT)	70.0%	83.6%
General Surgery	60.9%	83.9%

(Source: NHS England)

Cancer waiting times – Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers)

Up until Q4 2018/19 the trust has performed worse than both the 93% operational standard for people being seen within two weeks of an urgent GP referral and the England average. The graph below shows an improving trajectory and from Q4 2018/19 onwards, performance was similar to the England average and the 93% operational standard.

Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers), Bradford Teaching Hospitals NHS Foundation Trust

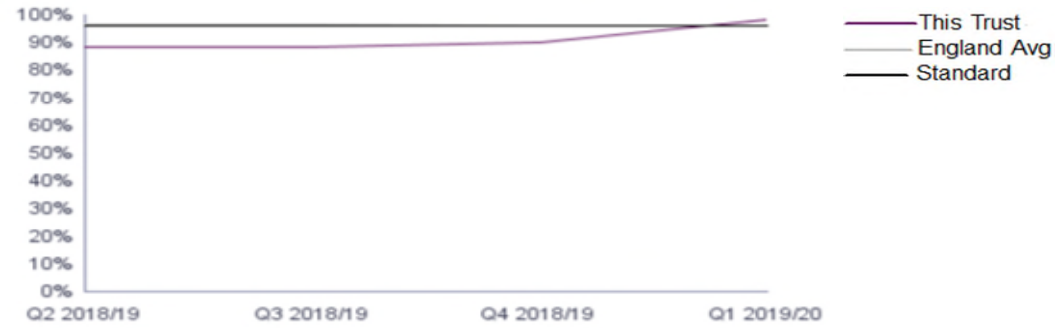


(Source: NHS England – Cancer Waits)

Cancer waiting times – Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers)

Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers), Bradford Teaching Hospitals NHS Foundation Trust

The chart below shows that from Q2 2018/19 to Q4 2018/19 the trust was performing worse than both the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a diagnosis (decision to treat) and the England average. However, Q4 2018/19 the trajectory has been improving with the performance in Q1 2019/20 being above the operational standard and the England average.

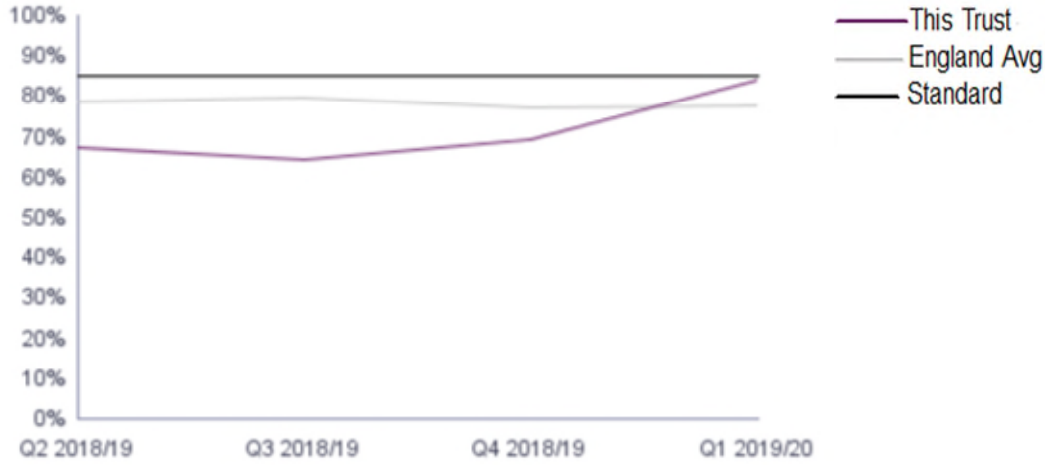


(Source: NHS England – Cancer Waits)

Cancer waiting times – Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment

The chart below shows that from Q2 2018/19 to Q4 2018/19, the trust is performing worse than both the 85% operational standard for patients receiving their first treatment within 62 days of an urgent GP referral and the England average. Q1 2019/20 shows that an improvement has occurred and the trust is now similar to the operational standard and better than the England average.

Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment, Bradford Teaching Hospitals NHS Foundation Trust



(Source: NHS England – Cancer Waits)

Learning from complaints and concerns

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

Patients, relatives and carers we spoke with knew how to complain or raise concerns if they needed to. Feedback and complaints could be submitted via links on the trust's patient experience web page.

The service displayed clear information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them. Staff we spoke with explained most complaints related to waiting times in clinics. They told us if a delay reached 20 minutes, they apologised to patients that were waiting and explained the reason for the delay. If patients remained unsatisfied, staff escalated patient concerns to the team leader, who saw the complainant personally.

Trust level

From August 2018 to July 2019 the trust received 54 complaints in relation to outpatients at the trust (10.3% of total complaints received by the trust). The trust took an average of 62.9 working days to investigate and close complaints. This was in line with their complaints policy, which stated responses to complainants would be within a maximum period of six months.

A breakdown of complaints by type is shown below:

Type of complaint	Number of complaints	Percentage of total
Surgical Group	20	37.0%
Appointments including delays and cancellations	13	24.1%
Patient Care including Nutrition/Hydration	6	11.1%

Communications	5	9.3%
Values and Behaviours (Staff)	2	3.7%
Accident and Emergency	2	3.7%
Anaesthetics	1	1.9%
Dental Group	1	1.9%
Paediatric Group	1	1.9%
Facilities Services	1	1.9%
General Medicine Group	1	1.9%
Waiting Times	1	1.9%
Total	**54**	**100.0%**

Out of these 54 complaints in relation to outpatients, all referred to Bradford Royal Infirmary apart from the following fourteen complaints from St Luke's Hospital:

Type of complaint	Number of complaints	Percentage of total
Appointments including delays and cancellations	4	28.6%
Communications	2	14.3%
Surgical Group	2	14.3%
Patient Care including Nutrition/Hydration	2	14.3%
Dental Group	1	7.1%
Anaesthetics	1	7.1%
Waiting Times	1	7.1%
General Medicine Group	1	7.1%
Total	**14**	**100.0%**

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Number of compliments made to the trust

From August 18 to July 2019 there were 17 compliments about outpatients at the trust. A breakdown of compliments by site is below:

Site	Number of compliments	Percentage of total
St Luke's Hospital	10	58.8%
Bradford Royal Infirmary	7	41.2%
Total	**17**	**100.0%**

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Is the service well-led?

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

Staff we spoke with told us they felt there was good leadership within the service. They said leaders were visible, supportive and approachable.

Head of nursing and matrons met daily at a management huddle and discussed how any challenges were managed. Topics included incidents, compliments, staffing, equipment issues, daily operational issues and safety alerts.

Vision and strategy

The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

The trust vision and values were summarised within four key goals which were displayed on posters throughout the department. These were best quality services, seamless access, healthy as possible and for staff, best place to work. Staff we spoke with were familiar with the trust values.

Outpatient managers we spoke with explained outpatient services were incorporated into the overarching trust strategy and those of the individual specialities.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care.

Staff we spoke with told us they felt morale to be ‘very good’ and they had not experienced bullying within the service.

They told us results of the staff survey were fed back and managers promoted staff well being through staff focused social events.

Governance

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

Managers we spoke with explained, due to the structure of the trust, they did not hold outpatient specific governance or team meetings. However, clinical business unit governance and team meetings included care provided within inpatient and outpatient settings.

Senior staff we spoke with told us they attended monthly clinical governance meetings. Junior staff, healthcare assistants and clinicians were also encouraged to attend.

Management of risk, issues and performance

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

We reviewed the departmental risk registers for planned and unplanned care. These showed control measures in place to reduce the impact of the risks and risks were reviewed regularly.

Information management

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

Staff accessed required information systems. For example, the trust intranet, for policies, procedures, national guidance and latest trust news. Staff were supported by an internal information technology team when required.

The service had performance reports. For example, patient tracking list reports, which enabled the service to monitor the waiting lists and understand where there were challenges.

Information systems were used across the departments to provide safe patient care. For example, there were electronic patient records and an electronic incident reporting system.

Most staff we spoke with told us that the implementation of the electronic patient record (EPR) system was smooth. The trust had learned from challenges with implementation at other trusts and planned for these in advance of the roll out.

All electronic information systems were accessed by individual smart card and password. We observed that principles of the general data protection regulations (GDPR) were embedded.

Engagement

Leaders and staff actively and openly engaged with patients, staff and the public to plan and manage services.

Friends and family test feedback cards were used across the trust. Staff were proactive and took action to increase the response rate to the friends and family test. For example, they recognised regular attenders may not have realised they could complete a feedback card after every visit.

Staff changed the wording to attract responses, to ‘we want to know about your care today’. We saw some staff wore badges with this phrase on them to raise awareness of the importance of patient feedback.

There was a patient advice and liaison service for complaints and concerns, highlighted on posters and leaflets.

Patient feedback was actively sought and utilised to make changes to outpatient services.

The trust liaised with their local Healthwatch division to learn from case studies of patient experience.

Staff we spoke with told us senior leaders were accessible. We heard that board level executive directors and non-executive directors visited the outpatients department on a planned and unplanned basis.

All staff we spoke with were aware of a weekly ‘let’s talk’ magazine, which engaged staff at all levels of the organisation.

Staff we spoke with told us they felt listened to by managers.

Learning, continuous improvement and innovation

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

Leaders encouraged innovation.

Staff received recognition for innovation and patient experience improvements in the trust annual ‘Bradford’s brilliance’ awards and employee of the month.

Some staff we spoke with said they were supported to develop their career through further post graduate study.

The service supported student nurses on placement by allocating mentors to work with them. We saw students were given a structured programme which ensured they gained experience in a variety of outpatient settings.

The trust implemented an outpatient improvement programme as one of three main transformational improvement initiatives within the trust’s improvement agenda. The aim of the programme was to improve the utilisation of outpatient clinics and reduce the number of unnecessary outpatient attendances at hospital.

Examples of some of the improvement work streams included a two-way text messaging, booking and clinic utilisation tool. This allowed patients to confirm their attendance at booked appointments and acted as a reminder to attend.

The service also trialled ‘virtual clinics’ which converted a four-hour face to face clinic to a combined three hour face to face clinic plus a one hour long telephone assessment clinic. Analysis showed an increase of two follow-up appointments per session.