



# Quality Account 2017/18

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# Introduction

Every year, the Department of Health requires NHS healthcare providers to produce a Quality Account. This Account is made available to the public and outlines the priorities and achievements for the previous year relating to the quality of services provided and initiatives undertaken to improve the services delivered to local communities and stakeholders.

This report summarises the quality of services delivered by Bedford Hospital NHS Trust in 2017/18 against the priorities the Trust set in last year's Quality Account relating to patient safety, clinical effectiveness and patient experience.



Underpinning the quality account priorities is the Trust's three year quality strategy which ended in 2017/18. The key objectives of the strategy are to:

- Deliver safe care
- Deliver reliable care
- Deliver an excellent patient experience
- Embed a learning and quality culture
- Deliver effective quality governance

You can read more about the Trust's key quality achievements over the last year in section X.

This report also sets out the Trust's quality improvement goals and actions for 2018/19.

The Trust has implemented its Quality Improvement Strategy which will guide its quality priorities over the next three years.

## **Deliver safe care and minimise harm**

The trust has reduced the overall falls with serious harm from 10 in 2016/17 to 8 in 2017/18, the number of avoidable hospital acquired category three pressure ulcers has increased from one in 2016/17 to two in 2017/18 together with the suspected deep tissue injuries (SDTI) have increased from two to four as at 25/04/18. A theme from investigations has shown incomplete documentation of pressure relieving measures, an audit and improvement plan is in place.

The reporting, investigation and learning from hospital acquired thrombosis has made good progress, an audit has identifies areas for improvement and training has been put in place.

Nursing quality dashboards are embedded in the majority of the hospital and have shown positive areas of improvement when implemented.

## **Deliver reliable care**

The maternity department have made excellent progress on the departmental improvement journey with sustained improvements in key areas including patient experience.

Staffing has been a challenge throughout the trust with performance detailed in sections....  
The trust access target of 95% has also been challenging over the period of winter pressures.



### **Delivery an excellent patient experience**

An improvement in the average friends and family test (FFT) scores for 2017/18 has been shown on page 9 of the account

The inpatient survey has not been published at time of writing. The number of complaints is similar to the previous year and show the significant reduction has been sustained. A thematic review of end of life complaints has highlighted the importance of communication; the outcome of the review has been incorporated into clinical update training.

### **Embed a learning and quality culture**

Human factors training have been at the centre of training and learning events. Dashboards set up in Children's' Assessment Unit and critical care has shown improvement's in nurse quality indicators. The clinical audit process has been improving and a dashboard is being developed. More detail of the progress of clinical audits both national and local is described in section

### **Delivery effective quality governance**

Divisional governance business partners have been in place and are driving the governance agenda within the divisions. The trust risk register has been developed and improved to show a good understanding of the current clinical risks to our patients.

## Statement on quality from the Chief Executive

I am proud to present Bedford Hospital NHS Trust's Annual Quality Account for 2017/18. Over the last year, the Trust has improved its performance significantly in many areas thanks to the dedication of our staff, volunteers and the support of our patients. We really appreciate the support of our patients, local communities and partner organisations, notably the Bedford Hospital Charity, Friends of Bedford Hospital, and Healthwatch for their unfaltering commitment to support and improve the services provided by Bedford Hospital NHS Trust.

This year has been one of the busiest periods in the history of the NHS, and like many other hospitals we have seen a record numbers of patients attending our A&E department, a significant rise in emergency admissions and increasing numbers of patients admitted with complex health needs. Despite the additional pressures on our services the hard work and commitment of our staff has ensured we continue to provide high quality care to the patients of Bedfordshire and the surrounding areas. Our focus on quality has never wavered and all our staff, clinical and non-clinical, have found ways in which we can improve the quality and safety of our patient care. Thanks to this dedication the Trust has improved its performance significantly in many areas in the face of increasing demand.

We have worked hard to manage the increase in A&E attendances. Several significant changes over the last year have helped to relieve the strain placed on the A&E department, including:

- Our Ambulatory Emergency Care Unit (AECU) has dedicated space close to our outpatients department and allows adult patients with longer term conditions to be assessed, treated and discharged from hospital on the same day, without the requirement for an overnight stay.
- Our A&E department is 'streaming' patients with minor illnesses straight to the Cauldwell Medical Centre for G.P. services during normal working hours.

During 2016/17, Bedford Hospital integrated all our quality improvement initiatives into a single quality improvement strategy so all actions related to quality and safety are implemented in a consistent and robust way across the organisation. During 2017/18 we have seen the benefits of the consistent approach with considerable improvements in the quality of care provided to our patients.

Some of the key quality achievements for 2017/18 include:

- Mortality rates remain 'as expected'
- Low infection rates – including more than 500 days since the last hospital-apportioned MRSA bacteraemia case.
- Dementia wards (Harpur and Elizabeth wards) retained their quality marks from the Royal Colleges of Psychiatrists and Physicians that recognises the support given to older people
- Riverbank play area has been completely renovated to enhance the delivery of patient care and create a fun and exciting environment to improve experience of young patients whilst on the ward.
- Improvements across our maternity services in quality, culture and clinical outcomes
- New modular theatre that is integrated in the main theatre block and allows the undertaking of more complex surgery than the hospital's previous mobile theatre.
- Kicking off the implementation of the "The Gold Standards Framework for End of Life Care".
- A reduction in serious incident reports and complaints from 2016/17.



It has been as important as ever this year to listen to our patients, visitors, staff, volunteers, regulators and partner organisations as part of our efforts to drive improvements. We value patient participation in surveys and patient involvement in investigations when things go wrong so we can learn and minimise the chance of similar things happening again. We value complaints and compliments as they help us to improve our weaknesses and grow our strengths. We also value our close working relationships with patient representation groups such as Healthwatch and our own Patients' Council. Looking forward, we will build on the feedback gained this year to develop our priorities and focus on the areas that require further improvement in the coming year.

On behalf of the Board, I would like to say thank you to all of our staff and volunteers for their ongoing commitment to providing high quality, compassionate care in a safe environment to anybody needing the hospital's services, and for continuing to make improvements for our patients.

To the best of my knowledge and belief, the information contained in this report is accurate.



**Stephen Conroy**  
Chief Executive  
Bedford Hospital NHS Trust

# Part one: Review of 2017/18 quality improvement priorities

This section reviews the Trust's actions and performance against its 2017/18 quality improvement priorities.



The Trust continues to implement its strategic quality improvement plan which incorporates local quality initiatives, and longer-term quality improvement actions arising from inspections and professional visits.

Following consultation with staff, stakeholders and patient organisations, the Trust identified three key quality priorities for 2017/18.

## Priority 1: Patient safety

### 1a. Improve care for patients whose condition is deteriorating

During 2017/18, the Trust invested in a range of specialist training courses for front-line staff. This included a combination of mandatory and advanced courses aimed specifically at providing staff with enhanced skills to support patients whose condition is deteriorating, such as:

- Immediate Life Support (ILS)
- Paediatric Immediate Life support (PILS)
- National Early Warning Score (NEWS)
- Paediatric Early Warning Score (PEWS)
- Modified Early Obstetric Warning Score (MEOWS)
- Acute Life-Threatening Events Recognition and Treatment (ALERT)
- Bedside Emergency Assessment (BEACH) for clinical support workers

The number of inpatient cardiac arrests has fallen by 15% compared to the previous year. This improvement has been as a result of a combination of two factors: training clinical staff to recognise deteriorating patients and instigate timely treatment; and, efforts to improve the identification of patients nearing the end of their life, for whom resuscitation may not be in their best interests.

## 1b. Reduce the number of patients experiencing a fall while in hospital

In 2017/18, the Trust achieved a 20% reduction in the number of patients who experienced a fall while in hospital. Eight falls led to the patient suffering a fractured neck of femur. These cases were investigated using the Trust's Serious Incident (SI) process. Seven of the cases were identified as avoidable and mitigations were put in place to prevent future harm. Further information can be found on page 55.

## Priority 2: Clinical effectiveness priorities

Over the course of the year the Trust has strengthened its clinical audit support function. This included developing its annual audit plan, which is provided to both the Quality Board and the Clinical Quality and Risk Committee to:

- Provide an opportunity for overview, challenge and scrutiny
- Provide assurance that national audits are being undertaken and completed
- Present the link between audit and quality improvements

The Trust undertook all relevant national audits (42) and completed them (see page 16). The outcome of these audits was used to share learning and advance improvements linking back to Trust objectives and priorities.

The Trust identifies learning points following all clinical audits and, to illustrate, the following actions were taken as a result of the Diabetes Inpatient Audit:

- Insulin safety training for FY1 & FY2s was undertaken October 2017
- Bedtime snack function mandatory for all patients on insulin
- Development of link nurses on each ward to improve training for nurses in place
- Diabetes nurse training days every three months
- Patients are encouraged and given support where appropriate, to self-administer insulin as per local guidelines
- Connected blood glucometers installed on all adult wards December 2017

The Trust undertook 56 local audits which are opportunities for staff with interest in specific procedures to improve care and patient outcomes. One such audit was reducing the time to instillation of intravesical Mitomycin post-TURBT (Transurethral Resection of Bladder).

Following presentation of the findings at the quarterly clinical audit day for all clinical staff, a number of quality improvements were made:

- Training provided for recovery/theatre nurses and surgeons on reconstituting Mitomycin, instilling, managing spillages and draining
- Added spillage kits to theatre environment and training for nurses and Urologists
- When given, a single immediate instillation of chemotherapy should be administered within 24 hours after TURBT:
  - Audits show 100% compliance

Leading into the year 2017/18 the Trust had identified reduced assurance of VTE (venous thromboembolism) risk assessment and undertook an audit to establish a benchmark and key areas for improvement. The audit supported the quality strategy of improving risk assessment and identified areas for improvement. As a result, the following action was taken:

- Junior doctors underwent training which included:
  - Appropriate use of online VTE risk assessment tool
  - Bleeding risk
  - Thrombosis risk
  - Appropriate use of anticoagulants and awareness of non-vitamin K antagonist oral anticoagulants (NOACs)
- Flow charts/posters to be displayed in AAU and A&E to prompt juniors in completing VTE risk assessments within 24 hours and prescribing prophylaxis as per protocol
- VTE coordinator will continue chasing doctors/teams where VTE risk assessments have not been completed within 24 hours
- VTE risk assessment will be included in the Post Take Ward Round (PTWR) sheet to ensure assessment is not missed
- Consultant to ensure VTE risk assessment has been completed by the admitting doctor while undertaking the PTWR

## Priority 3: Patient experience priority

The Trust provided staff with a variety of training, including leadership development, coaching skills and over 30 development BURST workshops (short presentations arising from leadership courses).

These were 90 minute interactive sessions designed to give Trust staff the opportunity to learn new skills or understand how other departments operate within the organisation. The sessions concentrated on three key themes:

1. Understanding our business – a day in the life and our part in the chain
2. Maintaining our strength – building and maintaining effective teams
3. Equipping our people – tools, techniques and top tips

The Trust has also seen an improvement in its NHS Friends and Family Test (FFT) scores. The FFT was created to help service providers and commissioners understand whether patients are satisfied with the service received, and where improvements are needed. It is a quick and anonymous way for patients to share their views after receiving care or treatment across the NHS.

FFT data is gathered from each patient who is surveyed at discharge or following an appointment, via a text or paper survey. FFT data is collected in four categories: Accident and Emergency; Inpatients; Maternity Services; and, Outpatients. The data is analysed in three ways:

- Response rate
- Positivity of response
- Comments

Overall, the Trust receives a response rate in line with the national average or above, while the percentage of positivity on average sits within the national range of best practice for A&E and below for maternity and inpatients.

Supporting information received from other sources of feedback such as the annual inpatient survey, maternity survey, and complaints information are also used to help shape patient experience improvements in different areas.

Inpatient, maternity and A&E 2018/17 FFT scores are provided below:

Service area	Average score 2016/17	Average score 2017/18	Percentage improvement
Inpatients	92%	94%	2%
Maternity	93%	94%	1%
Accident and emergency	83%	86%	3%

In 2018/19 the Trust will:

- Review the themes within the narrative feedback of FFT comments and align with current training
- Develop a programme of engaging with difficult to reach patients to improve response rates e.g. in the care of the elderly, young people, people with dementia
- Target areas with low response rates.

# Part two: Quality improvement priorities for 2018/19

**This section sets out the Trust's quality improvement priorities for 2018/19. It details our planned improvements for each priority, how we will report and measure our progress and sets out our measures of success.**



Between December 2017 and January 2018, the Trust undertook a one-month consultation with patients, stakeholders and staff to identify the top three priorities the Trust should deliver in 2018/19. The delivery of these priorities will be supported by the new quality improvement strategy, which was approved in April 2018.

## Priority 1: Patient safety

**Reduce the number of inpatients who fall by 5% by implementing the following quality improvement actions:**

- Introduce a rapid MDT assessment post fall (SWARM) for any moderate and severe harm falls, this will commence in from May 2018. A rapid review of findings for each fall with harm will identify immediate actions to be taken. This will be shared at the falls improvement steering group and the matrons meetings to ensure learning is shared across the organisation.
- Introduce a quality improvement project to high risk ward areas to reduce the number of falls. A falls practitioner will support ward managers and link champions to improve the intentional rounding process at times during the day when most falls occur. A review of the environment will also be undertaken to improve visibility of highest risk patients.
- Falls Prevention Week planned for September 2018 in collaboration with other NHS Trusts
- Review the nursing quality dashboard to strengthen the monitoring of documentation and risk assessment highlighted in falls investigation.
- Support a positive culture regarding reduction of falls in each ward or department by recognition for wards that have a reduction in falls and harm.

**Progress will be monitored by**

We will monitor our progress in a number of different ways:

- The number of inpatient falls will be reported to Quality Board each month

- A falls report will be presented to matrons meeting each month to review trends and actions
- Falls with serious harm will be investigated as serious incidents and reported to Quality Board
- A thematic review of falls with serious harm will be reported to Quality Board and Quality and Clinical Risk Committee every six months.

#### **Outcome**

- A reduction in the number of inpatient falls by 5%
- A reduction in the number of inpatients who sustain a serious injury from a fall.

## **Priority 2: Clinical effectiveness priorities**

**Improve the diagnosis and treatment of sepsis by implementing the following quality improvement actions:**

- Strengthen the sepsis working group with representatives from key departments
- Re-run the 'perfect week' with ward/department based training and raised awareness of the sepsis six
- Ensure that patient leaflets are available in all clinical areas
- Provide rapid feedback and learning from sepsis audit to departmental leads, focusing on good practice
- Include sepsis training in mandatory clinical update for all relevant staff
- Implement patient group directive for neutropenic patients to ensure antibiotics are given within one hour of diagnosis of sepsis.

#### **Progress will be monitored by**

The number of key staff who have completed sepsis six training, the findings of the ongoing audit of red flag sepsis recognition and treatment in A&E.

#### **Outcome**

An increase in the number of patients with red flag sepsis who are identified early and treated within one hour of diagnosis with intravenous antibiotics.

## **Priority 3: Patient experience priority**

**Improve the experience of patients and their family at the end of their life by implementing 'The Gold Standards Framework for End of Life Care'.**

The Gold Standards Framework (GSF) is a systematic evidence-based approach to optimising care for people in the last year of life with any condition in any setting. GSF focuses on enabling generalists in community and hospital settings to work more effectively with specialists, to care for patients from early identification, right through to discharge home or care in the final days.

The Gold Standards Framework (GSF) Quality Hallmark Awards is an independently validated marker of excellence, recognised by the regulator CQC, commissioning bodies, NHS Choices and many others.

In accordance with other GSF accreditation processes the expected benefits include:

1. Self- Assessment against five clear standards of best practice – right person, right care, right place, right time, every time. The hospital team will demonstrate change by providing a portfolio of evidence including a statement of how they have achieved each standard and provide the supporting evidence.
2. Key Outcome ratios – demonstrating change and impact for patients with comparative measures of progress before and after training.
3. Audit – carry out 'After Death/ Discharge Analysis' (ADA) audit. Demonstrate change at the patient level before and after training and at the point of accreditation - to include feedback from patients/ carers.
4. Quality Assessment visit – reviewing the integration of the processes into everyday practice.

The Trust is supporting two clinical areas - Harpur Ward and Pilgrim Ward - to progress through the two year project. The program commenced with funding from Bedford Hospitals Charitable funds. In addition, the Trust will be reviewing and enhancing the experience of patients with two key quality issues regarding patient experience in end of life care:

- Identifying those patients who require a treatment escalation plan (TEP), having those difficult discussions and implementing the TEP
- Supporting doctors and staff with advanced communication skills training to have those conversations.

### **Progress will be monitored by**

A reduction in the number of patients who suffer a cardiac arrest that should have had a TEP in place.

### **Outcome**

An enhanced experience for patients and family, demonstrated through an improvement in the results of the bereavement survey.

# Part three: Supporting evidence

This section provides a series of statements of assurance and other information relevant to the quality of health services provided by (or sub-contracted) by the Trust.



## Participation in national clinical audits

Clinical audit is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. National clinical audit is designed to improve patient outcomes across a wide range of health conditions. Its purpose is to engage all healthcare professionals across England and Wales in systematic evaluation of their clinical practice against standards and to support and encourage improvement in the quality of treatment and care. It also allows hospitals of similar size to benchmark their practice with each other.

During 2017/18, national clinical audits covered relevant health services that Bedford Hospital NHS Trust provides. During 2017/18 Bedford Hospital NHS Trust participated in 100% (42/42) of national clinical audits.

**The national clinical audits in which Bedford Hospital NHS Trust was eligible to participate, and for which data collection was completed during 2017/18**

*Table 2: National clinical audits in which Bedford Hospital NHS Trust was eligible to participate*

<b>Bedford Hospital NHS Trust participation in national clinical audits</b>	<b>Percentage participation /Continuous</b>
Acute Coronary Syndrome or Acute Myocardial Infarction	Continuous
Bowel Cancer (NBOCAP)	Continuous
Cardiac Rhythm Management (NICOR)	Continuous
Case Mix Programme (CMP)	Continuous
Coronary Angioplasty (NICOR adult cardiac interventions audit)	Continuous

Diabetes (paediatric) (NPDA)	Continuous
Elective Surgery (national PROMS programme)	Continuous
Endoscopy audits (38 topics)	Continuous
Endocrine and Thyroid National Audit (BAETS)	Continuous
Falls and Fragility Fractures Audit Programme (RCP) Fracture Liaison Database Inpatient Falls National Hip Fracture Database	Continuous Continuous Continuous
Female Stress Urinary Incontinence Audit (BAUS)	Continuous
Fractured Neck of Femur (RCEM)	In Progress
Head and neck oncology (DAHNO)	Continuous
Inflammatory bowel disease audit	Continuous
Learning Disabilities Mortality Review Programme (LeDeR)	Continuous
Major Trauma Audit (Trauma Audit & Research Network)	Continuous
Maternal, Newborn & Infant Clinical Outcome Review Programme (MBBRACE)	Continuous
National Audit of Breast Cancer in Older Patients (NABCOP)	Continuous
National Audit of Dementia	Continuous
National Cardiac Arrest Audit (NCAA)	Continuous
National Chronic Obstructive Pulmonary Disease Audit Programme – Pulmonary Rehab	In progress
National Chronic Obstructive Pulmonary Disease Audit Programme - (BTS)	In progress
National Comparative Audit of Blood Transfusion Programme: Use of Blood in Haematology	In progress
National Dementia Audit (RCP)	Completed
NADIA National Diabetes Audit	Continuous
NADIA National Diabetes - Inpatient Adult	Continuous
National Pregnancy in Diabetes Audit	Continuous
NADIA National Diabetes – Foot Care Audit	Continuous

National Emergency Laparotomy Audit	Continuous
National Heart Failure Audit	Continuous
National Joint Registry (NJR)	Continuous
National Lung Cancer Audit (NLCA)	Continuous
National Maternity and Perinatal Audit	Continuous
Neonatal and Intensive Special Care (NNAP)	Continuous
National Vascular Registry	Continuous
Oesophago-gastric cancer (NAOGC)	Continuous
Pain in Children (RCEM)	In progress
Percutaneous nephrolithotomy (PCNL) audit	Continuous
Procedural Sedation in Adults – Care In Emergency Departments (RCEM)	In progress
Prostate Cancer (RCSE)	Continuous
Sentinel stroke national audit programme (SSNAP)	Continuous

Following these audits, reports were shared with the relevant clinical teams and actions undertaken to address any findings or recommendations.

### National clinical audit reports

Table 3: National clinical audit reports received during 2017/18

National Audit	Actions
Heart Failure (National Heart Failure Audit) (NICOR) (2015-16)	<ul style="list-style-type: none"> <li>Discussed at cardiology team meeting</li> <li>Business plan being drawn up to recruit additional heart failure nurses to help achieve best practice tariff for the Trust</li> </ul>
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP) (2015-16)	<ul style="list-style-type: none"> <li>Discussed at cardiology team meeting</li> <li>Findings give the Trust assurance of good practice and thoroughness of data submission</li> </ul>
Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI) (NICOR) (January – December 2015)	<ul style="list-style-type: none"> <li>Discussed at cardiology team meeting</li> <li>No action required</li> </ul>

<p>National Adult Asthma Audit 2016</p>	<ul style="list-style-type: none"> <li>• Discussed at respiratory team meeting</li> <li>• Respiratory Specialist Nursing team working towards achieving 95% compliance that patients: <ul style="list-style-type: none"> <li>○ Receive an asthma discharge bundle</li> <li>○ Have their peak expiratory flow (PEF) recorded if an inpatient</li> <li>○ Admitted to hospital following an asthma attack are discharged with inhaled corticosteroids</li> </ul> </li> </ul>
<p>National Diabetes Audit (NHS Digital) (2015-16)</p> <p>Report 2a: Complications of diabetes</p> <p>Report 2b: Associations between disease outcomes and preceding care)</p>	<ul style="list-style-type: none"> <li>• Discussed at diabetes team meeting</li> <li>• “Traffic light” indicators being used to drive completion and recording of all care processes</li> <li>• Version 2 of Diamond.net will have treatment targets (HbA1c, BP, Cholesterol) to assist with highlighting whether achieved or not</li> </ul>
<p>National Diabetes Inpatient Audit 2017</p>	<ul style="list-style-type: none"> <li>• Report circulated</li> <li>• For discussion at May Trust wide audit meetings</li> </ul>
<p>Falls and Fragility Fracture Audit Programme (FFFAP) – National Audit of Inpatient Falls</p>	<ul style="list-style-type: none"> <li>• Discussed at Integrated Medicine audit meeting</li> <li>• New Trust wide multifactorial falls risk assessment tool introduced</li> <li>• Included in the admission care bundle for patients aged ≥65 years is assessment of lying and standing blood pressure, any visual impairments, continence and a medication review</li> <li>• Monthly bed rails and call bell audits</li> </ul>
<p>National Diabetes Insulin Pump Audit (2015-16)</p>	<ul style="list-style-type: none"> <li>• Discussed at diabetes team meeting</li> </ul>
<p>National Diabetes Adults - NDFA (National Diabetes Foot Care) (NHS Digital) (2014-16)</p>	<ul style="list-style-type: none"> <li>• Discussed at diabetes team meeting</li> </ul>
<p>Lung Cancer (National Lung Cancer Audit) Annual Report 2017 (for audit period 2016)</p>	<ul style="list-style-type: none"> <li>• Report circulated and discussed at operational service meetings</li> </ul>
<p>National COPD Audit Programme (BTS)</p>	<ul style="list-style-type: none"> <li>• Quarterly reports discussed in respiratory meetings</li> <li>• Best practice tariff achieved in Q3</li> </ul>
<p>National COPD Audit Programme (BTS) - Pulmonary Rehabilitation Workstream (Supplementary report December 2017)</p>	<ul style="list-style-type: none"> <li>• Discussed at pulmonary rehab team meeting and with commissioners of the service</li> </ul>

National Audit of Dementia (2016/17)	<ul style="list-style-type: none"> <li>• Report discussed at QCRC and the Adult Safeguarding Board</li> <li>• Action to be discussed at May 2018 Trust wide audit meetings</li> </ul>
SSNAP (Sentinel Stroke National Audit Programme) (2016/17)	<ul style="list-style-type: none"> <li>• Change in service – relevant results will be discussed at both sites providing stroke services</li> </ul>
National Audit of Breast Cancer in Older Patients (NABCOP) (The Royal College of Surgeons of England) (Annual Report 2017)	<ul style="list-style-type: none"> <li>• Report circulated and discussed at operational service meetings</li> </ul>
Oesophago-gastric Cancer (National O-G Cancer Audit)( Annual Report 2017)	<ul style="list-style-type: none"> <li>• Report circulated and discussed at operational service meetings</li> </ul>
Bowel Cancer (National Bowel Cancer Audit Programme) )( Annual Report 2017)	<ul style="list-style-type: none"> <li>• Report circulated and discussed at operational service meetings</li> </ul>
National Prostate Cancer Audit (Royal College of Surgeons of England) Annual Report 2017 (for audit period 2015-16)	<ul style="list-style-type: none"> <li>• Report circulated and discussed at operational service meetings</li> </ul>
NPID (Pregnancy in diabetes) Report 2016	<ul style="list-style-type: none"> <li>• Discussed at joint service meeting</li> </ul>
National Vascular Registry (Royal College of Surgeons of England) ( Annual Report 2017)	<ul style="list-style-type: none"> <li>• Reports are discussed at vascular meetings</li> <li>• Gap analysis from the GIRFT recommendations and action plan development</li> </ul>
National Emergency Laparotomy Audit (NELA) (December 2015 – November 2016)	<ul style="list-style-type: none"> <li>• Discussed at Anaesthetic and Surgery audit meetings</li> <li>• Electronic emergency booking system live and in use to increase risk scoring</li> <li>• Reasons any for delays to theatre investigated and actioned as appropriate</li> <li>• CCC team assess patients following laparotomy to consider CCC admission requirements for organ support for mortality risk 5-10% and &gt;10%</li> </ul>
Intensive Care National Audit and Research Centre (ICNARC) - Case Mix Programme (2016 – 17)	<ul style="list-style-type: none"> <li>• Results reviewed at Critical Care team meetings</li> </ul>
National Joint Registry (Report 2016)	<ul style="list-style-type: none"> <li>• Discussed at T&amp;O Quality Group meeting</li> <li>• Review undertaken on Trust raised revision rates. These revisions were attributed to revisions undertaken following safety alerts on metal-on-metal implants. Once this data</li> </ul>

	removed revision rates are below the national average
Maternal, Newborn and Infant Clinical Outcome Review Programme (reporting of maternal deaths, stillbirths and neonatal deaths through MBRRACE) Report 2017 (for audit period 2013-15)	<ul style="list-style-type: none"> <li>Presented at O&amp;G Audit meeting 28.03.18</li> <li>New information pack for pregnant women</li> <li>Additional training delivered in caring for diabetic pregnant women</li> <li>SPA (Stop, Pause, Act) tool embedded as part of daily practice</li> <li>Additional training delivered in resuscitation of an infant</li> <li>GAP/GROW charts now able to be accessed by community midwives</li> <li>Fast track system in place for women with reduced foetal movements</li> </ul>
National Maternity and Perinatal Audit (NMPA) (Royal College of Obstetricians and Gynaecologists) (2015-16)	<ul style="list-style-type: none"> <li>Report circulated – awaiting discussion of shared learning</li> </ul>
National Paediatric Diabetes (NPDA) (Royal College of Paediatrics and Child Health) Report 2017 (for audit period 2012-15)	<ul style="list-style-type: none"> <li>Discussed at paediatric diabetes team meeting</li> <li>Ongoing improvements noted year on year</li> <li>Continuing to actively work towards improving blood glucose levels and HbA1C to achieve target ranges</li> </ul>
National Neonatal Audit Programme (NNAP) Report 2017 (for audit period 2016)	<ul style="list-style-type: none"> <li>Report circulated and learning discussed at paediatric audit meeting</li> </ul>

The Trust also submitted continuous data for 38 audits (including a patient experience survey) in endoscopy throughout the year as part of the Joint Advisory Service (JAG) accreditation incorporating the endoscopy global rating scale requirements.

## Bedford Hospital NHS Trust local audits

The reports of 56 local clinical audits were reviewed by Bedford Hospital NHS Trust in 2017/18 and the Trust intends to take the following actions to improve the quality of healthcare provided:

### Local clinical audits and associated actions:

Table 4: Local clinical audits and associated actions

Local clinical audit	Month presented	Actions
CTPA	April 2017	Education sessions scheduled reinforcing importance of carrying out a thorough and proper clinical assessment to include:

		<ul style="list-style-type: none"> <li>• Calculation of a Wells score</li> <li>• Rationalisation of DDimer request in the presence of alternative diagnosis</li> </ul>
CT head and neck audit	April 2017	NICE guidelines recommendations disseminated to Radiology to achieve the targets. Re-audit underway
Clinical effectiveness of AECU	June 2017	New guidelines on referral pathways under consideration. Re-audit underway
Patient centred alcohol detoxification using Clinical Institute Withdrawal (CIWA-ar) scale.	January 2018	<ul style="list-style-type: none"> <li>• Further training sessions for medical staff on use of CIEA-ar to be arranged to guide medical professionals in improving the management of patients with alcohol withdrawal</li> <li>• Re- audit planned (2018/19)</li> </ul>
<b>Planned Care</b>		
Review of referred histopathological breast specimen	April 2017	<ul style="list-style-type: none"> <li>• Re-audit referral patterns over 12 months ending June 2017</li> <li>• An immunohistochemical panel for lymphoid tissue is being optimised in the lab</li> </ul>
Knowledge and management of Compartment Syndrome	April 2017	<ul style="list-style-type: none"> <li>• Junior doctors and nurses given training on the identifying and managing compartment syndrome</li> </ul>
Epidural pyrexia and antibiotic prescribing	April 2017	<ul style="list-style-type: none"> <li>• Joint discussions undertaken between anaesthetics, obstetricians and paediatricians when evaluating pyrexia as an individual risk factor for sepsis, particularly in the presence of epidurals for labour analgesia</li> </ul>
Delayed discharges from Critical Care	June 2017	<ul style="list-style-type: none"> <li>• Findings presented to the April 2017 Quality Board Meeting</li> <li>• Annual re-audit</li> <li>• Unplanned readmission cases are discussed in M&amp;M meetings</li> </ul>
Perioperative hypothermia – prevention and management	June 2017	<ul style="list-style-type: none"> <li>• Implementation of NICE approved temperature measurement device for indirect measurement of core temperature</li> </ul>
Lung protective ventilation in Critical Care	4 July 2017 at CCC M&M meeting	<ul style="list-style-type: none"> <li>• PBW (Predicted body weight) added to patient details bar at the top of Metavision</li> <li>• Target tidal volumes based on PBW are being shared with staff</li> <li>• Annual re-audit</li> </ul>
Incompletely excised basal cell carcinomas in the	14 July 2017 at L&D OMF	<ul style="list-style-type: none"> <li>• Ongoing operator training to maintain 85% success rate</li> <li>• Introduction of dermoscopy for early diagnosis and marking of</li> </ul>

Head and Neck Region from 2014-2015	meeting	<p>margins</p> <ul style="list-style-type: none"> <li>• Implement a skin audit template for BCC</li> <li>• Ensure peripheral margin clearance and size is documented on histology form and on clinical proforma to improve data collection for audit purposes</li> </ul>
Incompletely excised squamous cell carcinomas in the head and neck region from 2014 - 2015	14 July 2017 at L&D OMF meeting	<ul style="list-style-type: none"> <li>• Achieve the minimum 95% success rate complete excision rate for SCCs in the head and neck region</li> <li>• Implement a skin audit template for SCC</li> <li>• Ensure peripheral margin clearance and size is documented on histology form and on clinical proforma to improve data collection for audit purposes</li> </ul>
Prostate cancer diagnosis with multiparametric MRI imaging of the prostate prior to needle prostate biopsy	November 2017	<ul style="list-style-type: none"> <li>• Findings presented at Surgery audit meeting, Radiology meeting and Urology meeting</li> <li>• Discussion with Radiology regarding implementing PI-RADS</li> <li>• Scientific paper drawn up presenting findings as compared to PROMIS study</li> <li>• After discussion of current prostate cancer pathway in light of audit/PROMIS findings, decision taken to continue biopsying those patients with negative MRIs</li> <li>• Re-audit May 2018</li> </ul>
Decision to admission times to Critical care Complex	CCC meeting November 2017	<ul style="list-style-type: none"> <li>• Implement a single documentation of decision time by doctors</li> <li>• New staff to be sent regular reminders of requirement</li> <li>• Annual re-audit</li> </ul>
Red cell transfusion on CCC	CCC meeting 11 November 2017	<ul style="list-style-type: none"> <li>• Ensure there is correlation of lab Hb with tHb on ABGs</li> <li>• Target of &lt;80 trigger for red cell transfusion agreed in sepsis/TBI (Traumatic brain injury)/ACS (Acute coronary syndrome) patients</li> </ul>
Best medical therapy in vascular patients	January 2018	<ul style="list-style-type: none"> <li>• Patients on antiplatelet therapy must be given PPI as well</li> <li>• All patients suffering from PVD (peripheral vascular disease) must receive lifelong lipid lowering medications (high intensity statin)</li> <li>• Clopidogrel should be the first line antiplatelet used in secondary prevention of PVD</li> </ul>
<b>Women and Children</b>		
Delivery time with use of Misoprostol (dosage) after	April 2017	<ul style="list-style-type: none"> <li>• Patient leaflet updated regarding expected duration of treatment from the 1<sup>st</sup> misoprostol given</li> </ul>

pregnancy loss		
Operative outpatient hysteroscopy	April 2017	<ul style="list-style-type: none"> <li>Measures introduced to increase attendance to appointments to include distribution of a patient information leaflet</li> <li>Re-audit</li> </ul>
Intrapartum antibiotic prophylaxis for group B streptococcal (GBS)	April 2017	<ul style="list-style-type: none"> <li>Staff awareness raised regarding use of GBS alert stickers</li> <li>Prospective audit to be scheduled</li> </ul>
Neonatal sepsis cycle 1	June 2017	<ul style="list-style-type: none"> <li>Teaching for paediatric doctors has taken place</li> <li>Posters in relevant clinical areas on risk factors and clinical indicators have been displayed</li> <li>Proforma for notes with flow diagram and table has been agreed</li> <li>Plans for discussions to take place with paediatric consultants regarding consideration of changes to blood culture usage/reporting</li> </ul>
Neonatal sepsis cycle 2	November 2017	<ul style="list-style-type: none"> <li>Meeting planned with Pathology to discuss implications of non-availability of blood culture and ability to repeat CRP in 24 hours in these babies</li> <li>Findings to be discussed in the perinatal/obstetric audit meeting</li> </ul>
Paediatric bronchiolitis management	June 2017	<ul style="list-style-type: none"> <li>Teaching session to be undertaken in A&amp;E to educate nursing and medical staff on evidence based management of children presenting with bronchiolitis</li> <li>To develop an integrated care pathway for managing children with bronchiolitis to improve and consistency of care across the trust</li> </ul>
Review of caesarean section rate at Bedford Hospital	June 2017	<ul style="list-style-type: none"> <li>Introduction of a MDT meeting to review caesarean section (CS) cases weekly</li> <li>Methods of reducing the rate of C-sections should be a priority for the department</li> <li>Re-audit</li> </ul>
Induction Pathway	June 2017	<ul style="list-style-type: none"> <li>Indications and time of inductions are reviewed</li> <li>A pathway for induction of labour is under development</li> </ul>
Labour analgesia regime change from PCEA to PIB (Programmed intermittent bolus)	Sept 2017	<ul style="list-style-type: none"> <li>Use of PIB in place of PCEA will be instituted for delivery of epidural analgesia in labour where appropriate</li> </ul>

Time to antibiotic administration in newborn babies following decision to treat – QI topic	November 2017	<ul style="list-style-type: none"> <li>• IV cannula packs are available on Delivery Suite and Orchard ward</li> <li>• IV cannula checklist to be included in the IV cannula packs</li> <li>• A paediatric intravenous trolley is to be available on Delivery Suite and regular stock checking in place to identify out of date bottles and sampling bottles</li> </ul>
Management of babies with maternal thyroid disorder	Nov 2017	<ul style="list-style-type: none"> <li>• Paediatric alert to be generated for babies with maternal hyperthyroidism</li> <li>• A parent leaflet to be developed about symptoms of neonatal hyperthyroidism</li> <li>• Maternal antibody status to be checked before deciding on TFT/TRAb for baby</li> <li>• Day 5 blood spot is sufficient for babies born to mothers who are hypothyroid and have no history of hyperthyroidism/Hashimoto's disease</li> <li>• TFTs in newborns to be performed only when required</li> <li>• Re-audit to be scheduled using new network guidelines</li> </ul>
Paediatric antibiotic prescribing audit	Sept 2017	<ul style="list-style-type: none"> <li>• Discuss with Microbiology regarding bedside tests for RSV during the bronchiolitis season</li> <li>• Review of antibiotic prescription 2-3 days after commencement and plan whether antibiotics need to be continued</li> <li>• To develop a sticker for patients who will be ambulated from the ward for IV antibiotics</li> <li>• LP should be considered and performed prior to commencing antibiotics</li> </ul>
<b>Patient safety</b>		
<b>Integrated Medicine</b>		
Oxygen audit	Nov 2017	<ul style="list-style-type: none"> <li>• Implementation of teaching of medical and nursing staff on AAU, Pilgrim and Godber wards</li> <li>• Meeting being arranged with EPMA Pharmacy technician to discuss adaptation of software to encourage oxygen prescribing</li> <li>• Meeting planned with Head of Therapies to educate both physiotherapists and occupational therapists regarding the use and prescribing of oxygen</li> <li>• Findings and action to be presented at Integrated Medicine audit meeting</li> <li>• Re-audit</li> </ul>

Diagnosis and management of acute kidney injury (AKI) in acute medical admissions	January 2018	<ul style="list-style-type: none"> <li>• Renal check list is being created</li> <li>• Local guidance being updated</li> <li>• Plan to introduce renal teaching on training days</li> <li>• A designated lead consultant for AKI to be agreed</li> <li>• Plans for on call ultrasound services at weekends</li> </ul>
Falls leading to a hip fracture in elderly inpatients	January 2018	<ul style="list-style-type: none"> <li>• To look into the provision of additional staff to offer intentional rounding; 1:1 or cohort nursing in the COE wards</li> <li>• To undertake an investigation to assess whether level of exercise provided by Physio has an impact on the reduction of falls</li> </ul>
New oral anticoagulants (NOACs) - CCG prescribing quality audit for GPs	January 2018	<ul style="list-style-type: none"> <li>• Presented at Integrated Medicine audit meeting</li> <li>• Discussion to take place at the Hospital Acquired Thromboembolism (HAT) Committee regarding: <ul style="list-style-type: none"> <li>✓ Greater emphasis on NOAC prescribing in FY1 induction and training including prescribing competency assessment</li> <li>✓ To investigate the possibility for a MedChart prompt tagged to low dose Apixaban prescribing</li> </ul> </li> <li>• During weekly Pharmacy Clinical Services Meeting focus will be on NOAC to educate staff on identifying incorrect NOAC prescribing</li> </ul>
VTE risk assessment	January 2018	<ul style="list-style-type: none"> <li>• Junior doctors training to cover: <ul style="list-style-type: none"> <li>✓ Appropriate use of online VTE risk assessment tool</li> <li>✓ Bleeding risk</li> <li>✓ Thrombosis risk</li> <li>✓ Appropriate use of anticoagulants and awareness of newer anticoagulants (NOACs)</li> </ul> </li> <li>• Flow charts/posters to be displayed in AAU and A&amp;E to prompt juniors in completing VTE risk assessments within 24 hours and prescribing prophylaxis as per protocol</li> <li>• VTE coordinator will continue chasing doctors/teams where VTE risk assessments have not been completed within 24 hours</li> <li>• VTE risk assessment will be included in the Post Take Ward Round (PTWR) sheet to ensure assessment is not missed</li> <li>• Consultant to ensure VTE risk assessment has been completed by the admitting doctor while undertaking the PTWR</li> <li>• Re-audit annually</li> </ul>

Planned Care		
News response and observation chart	April 2017	<ul style="list-style-type: none"> <li>• Discuss if ward name should be removed on observation chart</li> <li>• Introduction of escalation sticker for patient notes</li> <li>• Education for all on when <u>not to</u> complete observations/NEWS scoring to utilise DNAR/TEP accurately</li> </ul>
Continuous wound infiltration observations documentation - pain buster	June 2017	<ul style="list-style-type: none"> <li>• Re-audit with a larger sample planned for December 2017 – to include auditing efficiency of pain buster against pain and nausea score</li> <li>• Ongoing annual and new starter training organised</li> </ul>
Out of theatre sedation	Sept 2017	<ul style="list-style-type: none"> <li>• Escalated to Planned Care management team that monitoring of in and out of theatre sedation has been increased</li> </ul>
Discharge letters in the surgical departments - discharging safely under maxim (DSUM)	Nov 2017	<ul style="list-style-type: none"> <li>• Teaching session for FY1s and final year medical students planned</li> <li>• ExtraMed template to be altered to capture information recommended in the Academy of Medical Colleges (ARMC) guidelines</li> <li>• Plan to present the findings at a national/international conference</li> <li>• Re-audit April 2018</li> </ul>
Anti-embolic stockings (AES) for venous thromboembolism (VTE) prophylaxis for surgical patients	Nov 2017	<ul style="list-style-type: none"> <li>• A patient information leaflet is being devised providing written information on AES for VTE prophylaxis as per NICE guidance</li> <li>• Training workshops to be arranged for nursing staff to raise awareness of importance of VTE prevention and measurement/accurate administration of AES</li> <li>• Posters to be devised to aid medical staff in undertaking discussion/prescription of AES with patients</li> <li>• To liaise with MedChart developers to change administration of AES from OD to QDS to prompt nursing staff to issue and confirm administration of AES within 24 hours of admission</li> <li>• Re-audit once action implemented (2018/2019)</li> </ul>
Women and Children		
Children not attending appointments - safeguarding	Sept 2017	<ul style="list-style-type: none"> <li>• Plans for a template letter from community paediatricians circulated to hospital paediatricians highlighting the potential safety implications of children not attending appointments</li> <li>• Clarification at Trust level to be sought regarding the difference</li> </ul>

children and young people		<p>between DNA versus cancellation i.e. if patient cancels within 24 hours which classification does this fall in</p> <ul style="list-style-type: none"> <li>To review the current methods used for sending appointment reminders</li> <li>Outpatient receptionist now prints clinic list which highlights those patients with a child protection plan to assist the clinician with following the correct protocol</li> <li>To assist with nursing staff awareness of the DNA policy, a laminated copy to be displayed in the outpatient area</li> <li>Re-audit September 2018</li> </ul>
Review of serious incident reports in Paediatrics (January 2014 to December 2016)	Sept 2017	<ul style="list-style-type: none"> <li>Record keeping and communication highlighted to all doctors joining the Trust during induction and ongoing during their placement</li> <li>Handover of ill patients and jobs to be structured and appropriately carried out</li> <li>Process of pathology results to be reviewed</li> </ul>
<b>Trust wide</b>		
Mental Capacity Act / deprivation of liberty	April 2017	<ul style="list-style-type: none"> <li>Continue to deliver Mental Capacity Act Training to all clinicians, using the audit findings to target appropriate groups, and themes for the training</li> <li>Improve Safeguarding Record keeping in Patient Records</li> </ul>
<b>Patient experience</b>		
<b>Integrated Medicine</b>		
Triage audit – CTAS introduced in A&E – helps in prioritising patients in A&E	April 2017	<ul style="list-style-type: none"> <li>Helps in prioritising patients in A&amp;E thus maintaining patient safety and appropriate early intervention.</li> <li>Re-audit</li> </ul>
Pre alert audit – Red calls (severity assessment) – prioritising the pre alerts	April 2017	<ul style="list-style-type: none"> <li>Found that these were appropriate and have to be acted on immediately on arrival</li> </ul>
Patient satisfaction questionnaires for: Acute cancer, Breast cancer, Colorectal cancer, Gynaecology cancer, Haematology cancer, Head and	May 2017	<ul style="list-style-type: none"> <li>Discussed at operational meetings in May &amp; June 2017</li> </ul> <p>ACT:</p> <ul style="list-style-type: none"> <li>Division to review 7 day provision of service</li> <li>Ensure patients receive information about the Acute Oncology team</li> </ul> <p>Colorectal:</p>

<p>Neck cancer, Lung cancer, Skin cancer, Upper GI cancer, Urology cancer,</p>		<ul style="list-style-type: none"> <li>• Ensure that patients do not feel rushed at their appointment</li> </ul> <p>Gynaecology</p> <ul style="list-style-type: none"> <li>• To ensure that patients are able to ask questions at their appointment</li> <li>• To ensure that follow up appointments are booked according to protocol</li> </ul> <p>Lung:</p> <ul style="list-style-type: none"> <li>• To improve communication between hospitals responsible for patients care and to ensure that patients are involved in their treatment and have adequate thinking time</li> </ul> <p>Skin:</p> <ul style="list-style-type: none"> <li>• To ensure that patients feel that they are fully involved in planning their care and treatment options; receive quick results; are referred promptly between teams and have enough time to consider treatment options</li> <li>• To ensure that patients are seen in clinic within 1 week of results being received and following diagnosis and treatment or consideration of nurse-led follow ups</li> <li>• All patients to have an end of treatment care plan</li> </ul> <p>All sites</p> <ul style="list-style-type: none"> <li>• Ensure patients receive a written summary of their consultation and information on possible side effects</li> <li>• To ensure that all patients receive keyworker contact details and are able to easily contact their keyworker</li> <li>• To ensure that HNA are completed for all patients at appropriate points in the pathway</li> <li>• To ensure that patients are given contact details of who they can contact following discharge</li> </ul>
<p>Anticipatory prescribing patterns in end of life patients</p>	<p>June 2017</p>	<ul style="list-style-type: none"> <li>• Continued education of staff on the earlier recognition of dying and the role of anticipatory medications</li> <li>• Review of the electronic anticipatory prescribing tool underway</li> <li>• In process of conducting a review of discharge process for patients on anticipatory prescribing to include discharge letters and TTO process underway</li> </ul>
<p>Care for dying patients audit - dying in Bedford Hospital</p>	<p>June 2017</p>	<ul style="list-style-type: none"> <li>• End of Life Champions to receive and disseminate the key points within their specific clinical areas             <ul style="list-style-type: none"> <li>○ Communicate to all new staff on “Care of the Dying Patient”</li> </ul> </li> <li>• Recommendations to be shared at End of Life Steering Group for discussion and further action</li> </ul>

		<ul style="list-style-type: none"> <li>• Key points taken to Quality Board in July 2017</li> <li>• To collaborate with Primary Care regarding anticipated death</li> </ul>
<b>Women and Children</b>		
Misoprostal dosage and length of time to delivery after pregnancy loss	April 2017	<ul style="list-style-type: none"> <li>• Update of patient information leaflet regarding expected duration of treatment from the 1st misoprostol given</li> </ul>
<b>Trust wide</b>		
Inpatient pain audit	Nov 2017	<ul style="list-style-type: none"> <li>• Presented at both General Surgery and O&amp;G November 2017 audit meetings</li> <li>• For discussion at the December divisional Quality meetings</li> <li>• Ongoing annual re-audits – 2018 audit to include additional outcome measures to mirror national inpatient cancer audit questions regarding pain control and numbers of patients audited in O&amp;G and Paediatrics will be increased. Pain link nurses Trust wide to assist with audit data collection</li> <li>• Ongoing regular education in pain control management routinely delivered to nursing staff and through junior doctor teaching</li> <li>• The pain team, anaesthetic consultants and nominated O&amp;G consultant (SR) to ensure that explanation of available methods of pain relief together with anaesthesia and post op pain control (where relevant) takes place with the patient</li> <li>• Patient information leaflets on pain control management to be devised by the pain team</li> <li>• Paediatric staff to be reminded at their December 2017 quality meeting of the importance of documenting an actual pain score rather than ticking a box</li> <li>• To improve patient satisfaction in obstetrics a project is to be undertaken by the pain team, O&amp;G consultant and O&amp;G principle pharmacist to explore the possibility of certain groups of patients self-administering simple analgesia following natural/non complicated deliveries</li> <li>• From this audit a decision has been made that a larger sample of patients in each specialist area will be audited every 6 months on a rolling basis and will include a detailed analysis and presentation at the relevant audit meeting</li> </ul>
<b>Service Improvement</b>		

Planned Care		
Delayed discharges from Critical Care	April 2017	<ul style="list-style-type: none"> <li>Annual audits to monitor progress</li> <li>Unplanned readmission cases are discussed in M&amp;M meetings</li> <li>Findings presented at April 17 Quality Board</li> </ul>
Women and Children		
Caesarean section Service review	June 2017	<ul style="list-style-type: none"> <li>MDT weekly meetings review all CS cases with the aim of reducing the CS rate at Bedford Hospital</li> </ul>
Communication		
Integrated Medicine		
Stroke discharge summaries; documented driving advice	June 2017	<ul style="list-style-type: none"> <li>Findings also discussed at AAU teaching session to promote knowledge of driving advice following a stroke</li> <li>Poster created to prompt for information that must be included in the discharge summary</li> <li>Clerking proforma to include a section for the first ward round to document any advice re driving following a stroke</li> </ul>
Women and Children		
Paediatric handover audit	November 2017	<ul style="list-style-type: none"> <li>Neonatal nurse to be present at handover</li> <li>Handover of high risk procedures and other procedures requiring a paediatric doctor e.g. Tilt test</li> <li>Patient safety issues to be highlighted i.e. deteriorating patient, safeguarding issues</li> <li>Daily safety briefings (nurses and doctors) to highlight risks</li> <li>Re-audit to be scheduled and include information on interruptions, medical staffing, intensity and workload</li> <li>Paediatric Escalation policy to be updated</li> <li>Junior doctor rota in Seminar room to have accurate on doctor availability on various shifts</li> </ul>
Data quality and documentation		
Integrated Medicine		
Endometrial cancer histopathology reporting	October 2017	<ul style="list-style-type: none"> <li>Continue to type and provide a FIGO (International Federation of Gynaecology and Obstetrics) grade in the surgical reports of all the endometrial cancers diagnosed on pipelle endometrial biopsies. This is vital to determine the need for full surgical</li> </ul>

		<p>staging and whether the operation takes place in a cancer unit or cancer centre</p> <ul style="list-style-type: none"> <li>• To remain compliant with the Royal College minimum dataset guidelines</li> <li>• Pathology peer review verifies and improves the accuracy and quality of pathology diagnoses and interpretations, thereby appropriately reflecting the pathology data</li> </ul>
<b>Planned Care</b>		
Documentation and consent – Surgery	September 2017	<ul style="list-style-type: none"> <li>• Reiterate to the registrars and consultants, the importance of thoroughly completing the consent form</li> <li>• Organise a teaching session with F1 and F2s to educate them about appropriate documentation as per the Trust’s guidelines and to make them aware of the alert sheet and red stickers</li> </ul>
ENT consent audit	April 2017	<ul style="list-style-type: none"> <li>• Reminder to all clinicians to write in the name of the responsible consultant for patient and not just fill in the name of clinician taking consent</li> </ul>
<b>Women and Children</b>		
Intrapartum record keeping	April 2017	<ul style="list-style-type: none"> <li>• To improve completion of the electronic foetal monitoring tool once tool has been reviewed in accordance with the latest NICE guidance</li> <li>• To improve on fluid balance documentation for women in labour with the use of the SPA tool to encourage the completion on a shift basis</li> <li>• Re-audit</li> </ul>
<b>Resources</b>		
<b>Integrated Medicine</b>		
Cost effectiveness of new oral anticoagulants (NOAC)	Nov 2017	<ul style="list-style-type: none"> <li>• Study to be undertaken November 2018 to assess patients on NOAC and warfarin to assess efficacy and major end points outcome e.g. stroke, heart failure, major bleeding and cardiac death</li> </ul>

## Patient experience surveys and associated actions

The reports of three local patient experience surveys were reviewed by Bedford Hospital NHS Trust in 2017/18. Based on this, the Trust intends to take the following actions to improve the quality of healthcare provided.

Table 5: Patient experience surveys and associated actions

Local Patient Experience Survey	Actions
Medicine:	
Acute Respiratory Assessment Service (ARAS)	<p>Patients invited to leave contact details if they have a query with their condition:</p> <ul style="list-style-type: none"> <li>• All patients leaving contact details have been telephoned and queries resolved</li> <li>• Presentation of patient experience of the ARAS and ESDS services made to the March 2018 Trust Board by the Respiratory Specialist Nurse &amp; Team leader:               <ul style="list-style-type: none"> <li>○ issue raised of the lack of a permanent base on the hospital site for patients to be seen which has impacted on patients not knowing where to go on arrival at hospital</li> </ul> </li> <li>• Majority of patients happy with service provided</li> <li>• Findings fed back to:               <ul style="list-style-type: none"> <li>○ Acute Respiratory Assessment Service staff</li> <li>○ Respiratory Team</li> <li>○ Integrated Medicine Quality Group</li> <li>○ Community teams</li> </ul> </li> <li>• Annual survey – next questionnaire to be distributed May 2018</li> </ul>
Early Supported Discharge Scheme (ESDS)	<p>Patients invited to leave contact details if they have a query with their condition:</p> <ul style="list-style-type: none"> <li>• All patients leaving contact details have been telephoned and queries resolved</li> <li>• Presentation of patient experience of the ARAS and ESDS services made to the March 2018 Trust Board by the Respiratory Specialist Nurse &amp; Team leader:               <ul style="list-style-type: none"> <li>○ issue raised of the lack of a permanent base on the hospital site for patients to be seen which has impacted on patients not knowing where to go on arrival at hospital</li> </ul> </li> <li>• Majority of patients happy with service provided</li> <li>• Findings to be fed back to:               <ul style="list-style-type: none"> <li>○ Early Supported Discharge Scheme staff</li> <li>○ Respiratory team</li> <li>○ Physiotherapy technicians</li> <li>○ Integrated Medicine Quality Group</li> </ul> </li> <li>• Annual survey – next questionnaire to be distributed May 2018</li> </ul>
Home Oxygen Service	<p>Patients invited to leave contact details if they have a query with their condition or the service provided by BOC – the Home Oxygen provider</p> <ul style="list-style-type: none"> <li>• All patients who left contact details have been telephoned. Action included:               <ul style="list-style-type: none"> <li>○ A home visit took place to a patient to review their oxygen equipment</li> <li>○ Reassurance and advice given in response to a patient having problems with the oxygen mask</li> </ul> </li> <li>• Majority of patients happy with service provided</li> <li>• Findings fed back to:               <ul style="list-style-type: none"> <li>○ Respiratory Nursing team &amp; Respiratory team</li> </ul> </li> </ul>

- Commissioners of Home Oxygen Service
- BOC Healthcare
- Respiratory networks
- Integrated Medicine Quality Group
- Annual survey – next questionnaire to be distributed May 2018

### Monitoring of actions

The clinical audit team receive assurance that audit actions are implemented.

## National confidential enquiry into patient outcome and death (NCEPOD)

The NCEPOD that the Trust was eligible for and participated in, and for which data collection was completed during 2017/18, are listed below. Alongside the enquiry title are the numbers of cases submitted for each enquiry as a percentage of the number of registered cases required by the terms of that enquiry.

### Bedford Hospital NHS Trust participation in NCEPOD

*Table 6: Bedford Hospital's participation in National confidential enquiry into patient outcome and death (NCEPOD)*

NCEPOD	Percentage participation
Chronic Neurodisability	50%
Young People's Mental Health	60%
Acute Heart Failure	90%
Perioperative Diabetes	42% study is still open and the figures have not been finalised.

## Participation in clinical research

The number of patients receiving health services provided or sub-contracted by the Trust in 2017/18, that were recruited during that period to participate in research approved by a research ethics committee was 716. This includes both portfolio and non-portfolio studies. In addition to the above there are 589 patients in the follow up process.

Participation in clinical research demonstrates the Trust's commitment to improve the quality of care we offer and to contribute to wider health improvement. Our clinical staff stay informed of the latest treatment possibilities and active participation in research leads to successful patient outcomes.

The Trust was involved in conducting 19 clinical research studies in 2017/18 including the following areas: oncology; ophthalmology; cardiology; haematology; dermatology; surgery; midwifery; paediatrics; gastroenterology; anaesthetics and respiratory medicine.

More than 40 clinical staff participated in research approved by a research ethics committee at the Trust during 2017/18. These staff participated in research covering 11 specialties.

In the last three years, 94 publications have resulted from our involvement in National Institute for Health Research (NIHR), which shows our commitment to transparency and desire to improve patient outcomes and experience across the NHS. The Trust is actively engaged with Clinical Research Network Eastern.

## Commissioning for Quality and Innovation (CQUIN) framework

A proportion of Bedford Hospital NHS Trust’s income in 2017/18 was conditional upon achieving quality improvement and innovation goals agreed between Bedford Hospital NHS Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the CQUIN payment framework.

In 2017/18 six CQUINs applied to the Trust (listed in table 7). All were mandated nationally.

In addition there were three specialised CQUINs which were negotiated locally with NHS England:

- Medicines Optimisation
- Dose Banding
- Secondary Dental

*Table 7: Bedford Hospital NHS Trust achievement against 2017/18 CQUINs*

Indicator identifier	Description	Overall achievement of target (%) for 2017/18
1a	Health and wellbeing	0%
1b	Healthy food	100%
1c	Flu vaccination	100%
2a	Timely identification of sepsis	94.5%
2b	Timely treatment for sepsis	88%
2c	Antibiotic review	100%
2d	Reduction in antibiotic consumption per 1,000 admissions	100%

4	Improving services for people with mental health needs who present to A&E	100%
6	Offering Advice & Guidance	50%
7	NHS e-Referrals	25%
8	Supporting proactive and safe discharge	77.5%

## Care Quality Commission registration and compliance

Bedford Hospital NHS Trust is required to register with the Care Quality Commission (CQC) and its current registration status is with no conditions.

- The Trust has not participated in any special reviews or investigations by the CQC during the reporting period
- Following inspection by the CQC in December 2015 (and outcome report published in April 2016), the Trust delivered an action plan by January 2017 which responded to the recommendations within the CQC report.

The outcome of the inspection was the Trust was rated as 'Requires improvement'. The overall rating grid is shown in figure 1.

Figure 1: CQC inspection rating grid for Bedford Hospital (April 2016)

	Safe	Effective	Caring	Responsive	Well-Led	Overall
<b>Urgent &amp; Emergency Services</b>	Requires improvement	Good	Good	Good	Good	Good
<b>Medical Care</b>	Good	Good	Good	Good	Good	Good
<b>Surgery</b>	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
<b>Critical Care</b>	Good	Good	Good	Requires improvement	Good	Good
<b>Maternity &amp; Gynaecology</b>	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
<b>Children &amp; Young People</b>	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
<b>End of Life Care</b>	Good	Requires improvement	Good	Good	Good	Good
<b>Outpatients &amp; Diagnostic Imaging</b>	Requires improvement	Inspected but not rated	Good	Good	Requires improvement	Requires improvement
<b>Overall</b>	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	<b>Requires improvement</b>

The action plan underpinned the four Requirement Notices from the CQC and the Trust declared full compliance against all of the recommended actions in December 2016. The requirement notices related to:

- Dignity and respect: overcrowding and lack of privacy and dignity within the phlebotomy service
- Need for consent: explicit MCA (mental capacity act) documentation within decision making process
- Good governance: improve mandatory training and learning
- Staffing: ensure safe staffing in the paediatric assessment unit

### Assurance

During 2017/18 the CQC steering group continued to monitor and challenge on embedded learning and mitigations. The Trust continued to use a range of assurance tools to provide oversight on quality improvement:

- Internal and external inspections and peer reviews
- GIRFT (Getting It Right First Time) audits and visits
- National surveys/audits
- Monthly review and analysis of Insight (CQC intelligence report)
- Core and support service upward reporting to steering group

During the year, the Trust put forward a proposal to merge with the Luton and Dunstable University Hospital NHS Foundation Trust. The merger is anticipated to happen in 2018/19. Trust assumes if there is any delay it will provide an opportunity for CQC to re-inspect Bedford Hospital before that.

## Duty of candour

The Trust continues to comply with its statutory duty under the Duty of candour legislation which was published in 2014.

The Trust has a culture of being open and transparent in recognising where standards have not met the level we would consistently like. Duty of candour legislation supported that culture, and provided a corporate infrastructure to encourage all staff to actively engage with patients and relatives in that openness.

The Trust promotes its culture of openness and sees it as an integral part of a safety culture that supports organisational and personal learning. Individual members of staff who are professionally registered are separately subject to the professional duty of candour, which is overseen by the professional regulatory bodies.

Duty of candour compliance is also a key quality metric on the Trust's quality scorecard and compliance is monitored monthly. Compliance with Duty of candour requirements forms part of the Trust's monthly quality performance report to the Bedfordshire Clinical Commissioning Group.

### Learning from openness

When responding to complaints, the principles of duty of candour are complied with. The response letters from the chief executive are open and transparent and include an apology where necessary. The Trust encourages those involved in claims to observe duty of candour requirements, and the

standard letter to clinicians informing them of claims, which have not previously been considered as incidents or complaints, asks if the clinician has observed the requirement.

Duty of candour is integral to the SI process and all SI lead investigators will provide an opportunity to meet with a patient or relative and include their concerns into the investigation as well as presenting what the incident and level of potential harm may be.

Following the investigation, the outcome, actions and learning are shared with the patient or family to support them in understanding what went wrong, why and how the Trust will mitigate against similar harm happening again.

## Sign Up To Safety

The Trust's targets against the national Sign up to Safety campaign pledges are detailed below:

**Pledge one: put safety first. Commit to reduce avoidable harm in the NHS by 50% and make public our goals and plans developed locally.**

Bedford Hospital's pledge: progressively reduce avoidable harm. The Trust commits to progressively supporting the development of safety projects that will:

- Improve our mortality rates to the top 25 percent of safest hospitals
- Maintain the number of patients who receive harm free care to more than 95 percent
- Reduce the number of MRSA blood infections to zero each year
- Maintain percentage reduction of clostridium difficile
- Reduce the number of avoidable cardiac arrests by 20 percent
- Reduce numbers of category two pressure ulcers by 10 percent per 1000 bed days
- Reduce category three pressure ulcers by 10 percent per 1000 bed days
- Reduce the numbers of patients who suffer harm from falls by 20 percent
- Achieve zero avoidable VTE
- Improve discharge communication with the wider team
- Improve clinical systems and clinical information technology systems so they meet the needs of the user and contribute to safer practice and more effective communication.

**Pledge two: continually learn - make organisations more resilient to risks by acting on the feedback from patients and by constantly measuring and monitoring how safe their services are.**

Bedford Hospital's pledge: Develop effective and innovative ways to share and learn from patient safety incidents and patient experience. Bedford Hospital aims to be open and accountable to the public and patients and always driving improvements in care. In the spirit of openness and transparency, we pledge to publish a set of patient outcomes, patient experience and staff experience measures. The Trust will:

- Improve in-patient survey scores to show that patients are involved in choices about their care
- Report an increased satisfaction score for patients being treated with dignity
- Have an identified dignity champion for each ward/ department as a resource for staff, patients and relatives

- Ensure staff Friends and Family Test shows that staff feel valued as part of the care delivery team
- Ensure that clinical leadership development includes setting the quality agenda and quality improvement
- Ensure 95 percent of staff have an appraisal in which goals are aligned with the Trust's vision and values
- Ensure 95 percent of staff access induction which reflects the organisations vision, values and strategy
- Implement annual staff awards for quality
- Ensure that the board is visible and can be challenged through different channels
- Implement recommendations from Freedom to Speak Up are implemented in order to create an honest and open reporting culture
- Develop clear systems for reporting and learning from incidents.

**Pledge three: honesty - be transparent with people about their progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong.**

Bedford Hospital's pledge: be open and honest about patient safety issues and avoidable harms by:

- Sharing Trust board reports on the Trust's website and develop further safety information about harm and mortality and make this available
- Continuing to invite partners to participate in internal compliance reviews
- Supporting patients and carers in delivering self-care to reduce harm from pressure ulcers
- Continuing to implement duty of candour requirements and review our approach to support staff to ensure that implementation is effective
- Working with key stakeholders to support internal and external surveillance of our performance on patient safety and quality
- Listening to and engaging with staff and patients through patient feedback sources such as listening events
- Carrying out root cause analysis investigations where serious incidents occur and share these with the patient and/or their carers
- Offering face-to-face meetings with clinical and senior management staff to better understand the care and treatment that has been provided and learn from it
- Developing and implementing an awareness and training programme with staff and patients to be aware of mental health first aid
- Keeping the patient voice at the forefront of our business by ensuring a patient story is heard at the Trust Board meeting every month
- Continuing to encourage staff to speak up if they have any concerns about the quality and safety of patient care.

**Pledge four: collaborate - take a leading role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use.**

The Trust will participate in regional and national quality and safety programmes to review and improve the care it gives to patients. The Trust will work with others, including the Trust's Patient Council and local Healthwatch organisations, to develop and improve understanding of measuring

and monitoring safety and it will continue the collaborative work with commissioners and local community healthcare to reduce harm from pressure ulcers, supporting complex discharges and acute care in community settings.

The Trust will share its safety plans with the public, patients, staff and partners. The Trust will improve communication between hospital, primary care and other partners as patients move between different settings. The Trust will work across healthcare via our transformation programme to ensure patient focussed integrated care pathways that deliver safe and effective care.

**Pledge five: support - help people understand why things go wrong and how to put them right.**

The Trust will seek to ensure continuous quality improvement is a core value of the organisation and its staff. This means that staff must respond well to change and embrace initiatives, be open to new ideas and encourage forward thinking, taking ownership for continuous learning and self-development. Supporting this, the Trust has invested in a programme of organisational development to manage a cultural change. An example is incorporating human factors training in the maternity transformation programme and in Trust wide root cause analysis training.

The Trust is committed to ensuring that its workforce has the capacity and capability to deliver quality improvement. The Trust has started this work and has now recruited 'safety leads' and 'safety champions' who provide the driving force to improvements at a ward and team level. Safety Leads have the opportunity to report any challenges and seek support from Trust board members. Safety leads access the safety development programme which the Trust has commissioned from the University of Bedfordshire.

The Trust is committed to the development of a safety improvement plan to support its Sign up to Safety pledge, which includes:

- A Trust wide quality improvement capability approach that supports teams to lead and manage their own improvement work with a focus on coaching in quality improvement methodology
- Implementing service improvement programmes, with partners, across the STP
- Developing a patient safety brief to encourage involvement and understanding of our safety work
- Ensuring on-going improvement in the quality and safety of patient care through the clinical quality strategy
- Ensuring staff understand their responsibilities for patient safety through the Trust's core values framework
- Continuing to deliver root cause analysis investigation training to middle and senior managers
- Continuing a programme of incident investigation and risk management to all department and front-line managers
- Routinely monitoring the quality of care being provided across all services
- Challenging poor performance or variation in quality
- Incentivising and rewarding high quality care and quality improvement through promotion of vision and values, staff awards and listening events and roadshows.

## Data quality

Bedford Hospital NHS Trust submitted records during 2017/18 to the secondary uses service for inclusion in the hospital episode statistics which are included in the latest published data. The percentage of records in the published data:

- That included the patient's valid NHS number was:
  - 99.99 percent for admitted patient care;
  - 99.95 percent for outpatient care; and
  - 99.97 percent for accident and emergency care.
- That included the patient's valid General Practitioner registration code was:
  - 99.98% percent for admitted patient care;
  - 99.99% percent for outpatient care; and
  - 99.39 percent for accident and emergency care.

### Information governance toolkit

Bedford Hospital NHS Trust's information governance assessment report overall score for 2017/18 was 71% percent and was graded green on all requirements.

### Clinical coding accuracy

IGT clinical coding audit undertaken in March 2018 attained a level two for requirements 505 and 510. This is a decrease on last year with a primary diagnosis accuracy score of 92%. The findings of the audit demonstrated an excellent standard of coding accuracy, with areas that could be improved.

Bedford Hospital NHS Trust will be taking the following actions to improve data quality:

- Continued engagement with consultants and junior medical staff to improve clinical documentation.
- Introduction of focussed data quality groups for divisions.
- Better use of benchmarking tools
- Better use of technology through fast-follower work streams

## Learning from deaths

Using quarter three as the currently published data, during 2017/18 561 patients of Bedford Hospital NHS Trust died. This comprised the following number of deaths which occurred in each quarter of that reporting period

- 188 in the first quarter
- 169 in the second quarter
- 204 in the third quarter
- Quarter 4 data is unavailable at date

By February 2018 (quarter 3), 277 case record reviews and sixteen investigations were carried out in relation to all of the deaths included in the section above.

In sixteen cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 127 in the first quarter
- 108 in the second quarter
- 56 in the third quarter (completed – this does not account for ongoing reviews)
- Quarter 4 data is unavailable at date

To date, one of the 561 deaths were judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of:

- 0% of deaths which occurred in quarter one;
- 0.17% of deaths which occurred in quarter two;
- 0% of deaths which occurred in quarter three; and
- quarter 4 data is unavailable at date

These numbers have been estimated in that all deaths are under scope for review, excluding:

- deaths in the emergency department; and
- stillbirths.

Process for review

Deaths of children are subject to review under the Child Death Overview Process (CDOP) and therefore not included in trust mortality review. Similarly, deaths involving patients with learning difficulties are reviewed by the Learning Disability Liaison Nurse and from October 2017 reviews are being undertaken using the LeDER methodology.

The trusts' medical director is the executive lead for learning from deaths and reports quarterly to trust board. These assurance reports provide oversight of both the statistical information and learning from those deaths classed as avoidable. This is in line with NHS Improvement guidance. The Learning from Deaths policy was published on the external trust web site in September 2017 and the first quarterly report was published in October 2017.

The trust disseminates the medical notes from each patient death across the consultant body in the hospital for review of both care and treatment and assessment of avoidability of each death. Each review is carried out using an electronic mortality review tool with NCEPOD grading of quality of care and determination of a preventability score. The trust will be moving to the Structured Judgement Review in 2018/19 (developed by HQIP (Healthcare Quality Improvement Partnership) and the Royal college of Physician. Themes from reviews are presented to trust board and triangulated with investigation outcomes. Care reviews are presented for discussion at clinical audit days and speciality mortality meetings.

What we have learnt from case record reviews and investigations conducted in relation to the deaths  
The trust's mortality review group commissions 'deep dive' into particular health conditions or trends arising from mortality reviews and triangulates across deaths deemed to be avoidable. To date, no deaths have been reported as avoidable in the reporting period.

However, the trust takes seriously all deaths and seeks to learn from them. Themes that arose from case reviews where care could have been improved include:

- Poor documentation in recording and storage of notes
- Competency in undertaking procedures
- Not following correct clinical pathway
- Failure to escalate to the appropriate speciality for review or transfer
- Failure to follow protocol

Reviews and investigations found that it was hard to determine whether the outcome for patients would have been different had the learning and mitigations been in place at the time of death. However, the trust is committed to ensuring all patients are safe and well treated and cared for and will continue to embed learning from deaths. Following these reviews and investigations the trust took the following actions:

- Refocusing on the importance of timely escalation
- Reminders within specialities and clinical areas of the use of appropriate pathways, supported by in-date guidelines and protocols
- Ensuring learning from death reviews are conducted in a timely manner and learning is shared across clinical areas

An assessment of the impact of the actions

Action plans from serious incidents are monitored within clinical divisions and reported through quality board. Actions and improvements arising from mortality reviews are monitored through the mortality surveillance group and escalated to mortality board.

The number of deaths in the reporting period where care was suboptimal is low so while the actions to prevent reoccurrence are delivered at local level to ensure no repetition, trust wide impact is measured through maintaining overview of deaths, and investigations where failings may have contributed to them.

Learning from deaths was introduced in October 2017 and reporting from previous reporting period will be included in the quality account for 2018/19.

# Part three: National indicators in care quality 2017/18

Part three of the Quality Account presents data relating to national quality indicators. A quality indicator is a measure that can help inform providers of healthcare, patients and other stakeholders about the quality of services provided compared to the national average, the best performing Trust and the worst performing Trust. The indicators are also used by the Secretary of State to track progress across the whole of the NHS in meeting the targets that make up the NHS Outcomes Framework.



The NHS Outcomes Framework identifies five domains relating to clinical effectiveness, patient experience and safety. Progress in each domain is measured using many indicators, some of which must be included in a Trust's annual Quality Account. The five domains are presented in figure four.

Table 8: Five domains of the NHS Outcomes Framework

Domain	Outcome measure	Quality indicator
Domain one	Preventing people from dying prematurely	Clinical effectiveness
Domain two	Enhancing quality of life for people with long-term conditions	
Domain three	Helping people to recover from episodes of ill health or following injury	
Domain four	Ensuring that people have a positive experience of care	Patient experience
Domain five	Treating and caring for people in a safe environment and protecting them from avoidable harm	Safety

## Our performance against 2017/18 quality indicators

Eight Quality Account indicators apply to Bedford Hospital NHS Trust in 2017/18:

- Summary Hospital-Level Mortality Indicator (SHMI) including SHMI banding and percentage of patient deaths with palliative care coded at either diagnosis or specialty level

- Patient Reported Outcome Measures (PROMs) for:
  - Groin hernia surgery
  - Varicose vein surgery
  - Hip replacement surgery
  - Knee replacement surgery
- Readmissions to the hospital within 28 days of discharge for patients aged 0 to 15 and 16 and over
- Responsiveness to the personal needs of our patients
- Percentage of staff who would recommend the Trust to friends or family needing care
- Percentage of admitted patients who were risk assessed for venous thromboembolism (VTE)
- Rate of Clostridium difficile infections per 100,000 bed days
- Rate of patient safety incidents and the percentage resulting in severe harm or death.

## Summary Hospital-level Mortality Indicator (SHMI)

### Domains 1 and 2

The Summary Hospital-level Mortality Indicator (SHMI) is an indicator which reports on mortality at Trust level across the NHS in England using a standard and transparent methodology. It is produced and published quarterly as an official statistic by NHS Digital, (previously Health and Social Care Information Centre) and is reported six months in arrears.

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 on the basis of average England figures, given the characteristics of the patients treated there.

The SHMI indicator relates to two NHS outcomes framework domains: the first is preventing people from dying prematurely; and the second is enhancing the quality of life for people with long-term conditions.

Table 9: Summary Hospital-level Mortality Indicator (SHMI) for Bedford Hospital

	2015/16	2016/17	2017/18
<b>Bedford Hospital NHS Trust</b>	0.989 Band 2 'as expected' 27.4% palliative care	1.033 Band 2 'as expected' 25.3% palliative care	1.041 Band 2 'as expected' 26.3% palliative care
<b>England average</b>	1.00	1.00	1.00
<b>Best performing Trust</b>	0.652 Band 3 'lower than expected'	0.690 Band 3 'lower than expected'	0.727 Band 3 'lower than expected'
<b>Worst performing Trust</b>	1.177 Band 1 'higher than expected'	1.164 Band 1 'higher than expected'	1.247 Band 1 'higher than expected'

Source: Health and Social Care Information Centre (<https://indicators.ic.nhs.uk/webview>)

Notes:

- 2015/16 data = October 2014 to September 2015 (published March 2016)
- 2016/17 data = October 2015 to September 2016 (published March 2017)
- 2017/18 data = October 2016 to September 2017 (published March 2018)

Bedford Hospital NHS Trust considers that this data is as described for the following reason:

- The Trust SHMI is stable (the above figures are taken at a single yearly time point; data is reported quarterly’.

Bedford Hospital NHS Trust has taken the following actions to improve the number, and so the quality of its services, by:

- Proactive review of mortality metrics by the Medical Director and highlighted at Mortality Review Board
- Commissioned reviews of mortality outliers
- Learning from deaths framework implemented with oversight of peer review mortality process

## Patient Reported Outcome Measures (PROMs)

### Domain 3

PROMs collect information on the effectiveness of care delivered to NHS patients as perceived by the patients themselves. The data adds to the wealth of information available on the care delivered to NHS-funded patients to complement existing information on the quality of services.

Since 1 April 2009, hospitals providing four key elective surgeries for the English NHS have been inviting patients to complete questionnaires before and after their surgery. The PROMs programme covers four common elective surgical procedures: groin hernia operations, hip replacements, knee replacements and varicose vein operations.

PROMs for groin hernia surgery, varicose vein surgery, hip replacement surgery and knee replacement surgery relate to NHS Outcomes Framework domain three: helping people to recover from episodes of ill health or following injury.

### Groin hernia surgery

The scores of patients having undergone groin hernia surgery are based on the responses to a standard measure of health questionnaire. This questionnaire covers five areas:

- Mobility
- Self-care
- Usual activities
- Pain and discomfort
- Anxiety and depression

Patients indicate whether they experience no problems, some problems or severe problems in relation to each of the five areas in question. A higher overall score indicates better reported overall health following groin hernia surgery.

Table 10: Patient Reported Outcome Measures (PROMs) for Groin Hernia surgery

	2015/16	2016/17	2017/18
<b>Bedford Hospital NHS Trust</b>	0.064	0.067	Not applicable
<b>England average</b>	0.088	0.087	Awaiting publication (Aug 2018)
<b>Best performing Trust</b>	0.135	0.12	Awaiting publication (Aug 2018)
<b>Worst performing Trust</b>	0.008	0.006	Awaiting publication (Aug 2018)

Source: Health and Social Care Information Centre ( <http://www.hscic.gov.uk/proms>)

Notes: Adjusted average health gain data to allow for case-mix (EQ-5D)

- 2015/16 - data (published February 2016) for period April 2015 to September 2015
- 2016/17 - provisional data (published May 2017) for period April 2016 to December 2016
- 2017/18 – provisional data (published Feb 2018) for period April 2017 to September 2018

Bedford Hospital NHS Trust considers that this data is as described for the following reason:

- The Trust did not receive PROM score for groin hernia surgery for the reporting period

In line with guidance from NHS England, PROMS data collection for groin hernia was discontinued in October 2017 following national consultation as it was considered to be delivering limited clinical value. Follow-up questionnaires for existing patients will continue.

### Varicose vein surgery

The Aberdeen Varicose Veins Questionnaire (Aberdeen Questionnaire) is a condition-specific questionnaire that measures health status for patients with varicose veins. The questionnaire consists of 13 questions relating to key aspects of the problem of varicose veins. The questionnaire has a section in which the patients can indicate diagrammatically the distribution of their varicose veins. There are questions relating to the amount of pain experienced, ankle swelling, use of support stockings, interference with social and domestic activities and the cosmetic aspects of varicose veins.

A lower negative score indicates better reported outcomes by the patient.

Table 11: Patient Reported Outcome Measures (PROMs) for Varicose Vein surgery

	2015/16	2016/17	2017/18
Bedford Hospital NHS Trust	-4.17	-0.544	Awaiting publication (Aug 2018)
England average	-8.6	-8.61	Awaiting publication (Aug 2018)
Best performing Trust	-13.14	-18.075	Awaiting publication (Aug 2018)

Worst performing Trust	4.26	2.117	Awaiting publication (Aug 2018)
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Source: Health and Social Care Information Centre ( <http://www.hscic.gov.uk/proms>)

Notes: Adjusted average health gain data (Aberdeen Varicose Vein Score; a negative score indicates improvement)

- 2015/16 - data (published February 2016) for period April 2015 to September 2015
- 2016/17 - data (published Feb 2018) for period April 2016 to December 2016
- 2017/18 - provisional data (published May 2018) for period April 2017 to December 2017

Bedford Hospital NHS Trust considers that this data is as described for the following reason:

- The Trust did not receive PROM score for varicose vein surgery for the reporting period

In line with guidance from NHS England, PROMS data collection for varicose vein surgery was discontinued in October 2017 following national consultation as it was considered to be delivering limited clinical value. Surgery for varicose veins is less frequently used due to less invasive procedures being undertaken in line with NICE guidance. Follow-up questionnaires for existing patients will continue.

### Hip replacement surgery

The Oxford hip and knee scores are joint-specific outcome measure tools designed to assess symptoms and function in patients undergoing joint replacement surgery. The scores comprise of twelve multiple choice questions relating to the patient's experience of pain, ease of joint movement and ease of undertaking normal domestic activities such as walking or climbing stairs.

Each of the 12 questions on the Oxford Hip Score and Oxford Knee Score are scored in the same way with the score decreasing as the reported symptoms increase, i.e. become worse. All questions are presented similarly with response categories denoting least (or no) symptoms scoring four and those representing greatest severity scoring zero.

The individual scores are then added together to provide a single score with 0 indicating the worst possible and 48 indicating the highest possible score.

*Table 12: Patient Reported Outcome Measures (PROMs) for hip replacement surgery*

	2015/16	2016/17	2017/18
Bedford Hospital NHS Trust	21.61	21.405	Awaiting publication (Aug 2018)
England average	22.09	21.9	Awaiting publication (Aug 2018)
Best performing Trust	24.61	25.045	Awaiting publication (Aug 2018)
Worst performing Trust	18.13	17.36	Awaiting publication (Aug 2018)

Source: Health and Social Care Information Centre ( <http://www.hscic.gov.uk/proms>)

Notes: Adjusted average health gain data (Oxford Hip Score)

- 2015/16 - data (published February 2016) for period April 2015 to September 2015
- 2016/17 - data (published Feb 2018) for period April 2016 to December 2016
- 2017/18 - provisional data due to be published in May 2018 for period April 2017 to December 2017

Bedford Hospital NHS Trust considers that this data is as described for the following reason:

- The Trust did not receive data for PROM score for hip surgery for the reporting period

Bedford Hospital NHS Trust has taken the following actions to improve the number, and so the quality of its services, by:

- The Trust awaits the publication of official 2017/18 data to understand what improvements need to be made.

### Knee replacement surgery

In relation to the reported outcome of knee replacement surgery, individual scores on patient questionnaires are added together to provide a single score with 0 indicating the worst possible and 48 indicating the highest possible score.

*Table 13: Patient Reported Outcome Measures (PROMs) for knee replacement surgery*

	2015/16	2016/17	2017/18
Bedford Hospital NHS Trust	15.24	16.25	Awaiting publication (Aug 2018)
England average	16.4	16.7	Awaiting publication (Aug 2018)
Best performing Trust	19.34	19.687	Awaiting publication (Aug 2018)
Worst performing Trust	12.40	12.231	Awaiting publication (Aug 2018)

Source: Health and Social Care Information Centre ( <http://www.hscic.gov.uk/proms>)

Notes: adjusted average health gain data (Oxford Knee Score)

- 2015/16 - data (published February 2016) for period April 2015 to September 2015
- 2016/17 - data (published Feb 2018) for period April 2017 to December 2017
- 2017/18 - provisional data due to be published in May 2018 for period April 2017 to December 2017

Bedford Hospital NHS Trust considers that this data is as described for the following reason:

- The Trust awaits the publication of official 2017/18 data to understand what improvements need to be made.

Bedford Hospital NHS Trust has taken the following actions to improve the number, and so the quality of its services, by:

- The Trust awaits the publication of official 2017/18 data to understand what improvements need to be made.

## Emergency readmissions to the hospital within 28 days of discharge

### Domain 3

Emergency readmissions to the hospital within 28 days of discharge relates to NHS Outcomes Framework domain three: helping people to recover from episodes of ill health or following injury.

Table 14: Emergency readmissions to the hospital within 28 days of discharge

	2015/16	2016/17	2017/18
0 to 15 years of age	8.5%	9.19%	7.98%
16 years and over	10.7%	7.4%	7.68%

Source: Health and Social Care Information Centre (<https://indicators.ic.nhs.uk/webview> )

Notes:

- 2015/16 - data provided via CHKS source – admitted patient care dataset
- 2016/17 - data provided via CHKS source – admitted patient care dataset
- 2017/18 - data provided via CHKS source – admitted patient care dataset

Bedford Hospital NHS Trust considers that this data is as described for the following reason:

- The Trust accepts the published data.

Bedford Hospital NHS Trust intends to take the following actions to improve the percentage, and so the quality of its services, by:

- The Trust will continue to review and implement a reduction in readmission for under 16 years of age
- The Trust will work with its strategic partners and continue its improvement workstream to understand the influences and improvements to reduce readmission.

## Responsiveness to the personal needs of patients

### Domain 4

Responsiveness to the personal needs of patients relates to NHS Outcome Framework Domain four: ensuring people have a positive care experience.

Table 15: Responsiveness to the personal needs of patients

	2015/16	2016/17	2017/18
<b>Bedford Hospital NHS Trust</b>	63.7%	65.1%	Awaiting publication (Aug 2018)
<b>National average</b>	64.4%	68.1%	Awaiting publication (Aug 2018)
<b>Best performing Trust</b>	78.6%	85.2%	Awaiting publication (Aug 2018)
<b>Worst performing Trust</b>	51.9%	60.0%	Awaiting publication (Aug 2018)

Source: Health and Social Care Information Centre (<https://indicators.ic.nhs.uk/webview>)

Notes:

Bedford Hospital NHS Trust considers that this data is as described for the following reason:

- Data for 2017/18 is unavailable.

Bedford Hospital NHS Trust intends to take the following actions to improve the percentage, and so the quality of its services, by:

- The Trust awaits publication of data for 2017/18 to understand where to focus its improvements.

## Percentage of staff who would recommend the Trust to friends or family needing care

### Domain 4

The percentage of staff who would recommend the Trust to friends or family needing care related to NHS Outcomes Framework domain four: ensuring that people have a positive care experience.

Table 16: Percentage of staff who would recommend the Trust to friends or family needing care

	2015/16	2016/17	2017/18
Bedford Hospital NHS Trust	78%	72%	67%
England average	69%	70%	71%
Best performing Trust	89%	85%	86%
Worst performing Trust	46%	49%	47%

Source: Picker Institute Staff Survey

Notes:

Bedford Hospital NHS Trust intends to take the following actions to improve the score, and so the quality of its services, by:

- Continuing to provide staff opportunities to feedback their experience of working at the Trust;
- Listening events will take place to develop an engagement and improvement plan based on staff feedback. These listening events will continue during the year as a permanent engagement cycle of meetings.

## Percentage of admitted patients who were risk assessed for venous thromboembolism

### Domain 5

The percentage of admitted patients who were risk assessed for venous thromboembolism related to NHS Outcomes Framework domain five: treating and caring for people in a safe environment and protecting them from avoidable harm.

The scope of the indicator includes all adults (those aged 18 at the time of admission) who are admitted to hospital as inpatients including:

- surgical inpatients
- in-patients with acute medical illness (for example, myocardial infarction, stroke, spinal cord injury, severe infection or exacerbation of chronic obstructive pulmonary disease)
- trauma inpatients
- patients admitted to intensive care units
- cancer inpatients
- people undergoing long-term rehabilitation in hospital
- patients admitted to a hospital bed for day-case medical or surgical procedures
- private patients attending an NHS hospital.

The following patients are excluded from the indicator:

- people under the age of 18 at the time of admission
- people attending hospital as outpatients
- people attending emergency departments who are not admitted to hospital
- people who are admitted to hospital because they have a diagnosis or signs and symptoms of deep vein thrombosis (DVT) or pulmonary embolism.

Table 17: Percentage of admitted patients who were risk assessed for venous thromboembolism

	2015/16	2016/17	2017/18
Bedford Hospital NHS Trust	95.64%	97.64%	98.12%
England average	95.75%	95.6%	Awaiting publication

Best performing Trust	100%	100%	Awaiting publication
Worst performing Trust	75.15%	79.14%	Awaiting publication

Source: NHS England (<http://www.england.nhs.uk/statistics/statistical-work-areas/vte/>)

#### Notes:

2017/18 - not yet published nationally

Bedford Hospital NHS Trust considers that this data is as described for the following reasons:

- The Trust has maintained its performance in relation to the 95 percent assessment target.

Bedford Hospital NHS Trust has taken the following actions to improve the percentage of patient assessed, and so the quality of its services, by:

- Continuing to provide Trust wide support and expertise via the haemostasis and thrombosis (HAT) committee.
- Teaching of Junior Doctors
- Audits.

## Rate of Clostridium difficile infections

### Domain 5

The rate of clostridium difficile infections relates to NHS Outcomes Framework domain 5.2.ii: treating and caring for people in a safe environment and protecting them from avoidable harm.

The rate per 100,000 bed days of cases of clostridium difficile infections (CDI) that have occurred within the Trust amongst patients aged two or over during the reporting period.

The scope of the indicator includes all cases where the patient shows clinical symptoms of clostridium difficile infection and has a positive laboratory test result. A clostridium difficile infection episode lasts for 28 days, with day one being the date the first positive specimen was collected. A second positive result for the same patient, if collected more than 28 days after the first positive specimen, should be reported as a separate case, irrespective of the number of specimens taken in the intervening period, or where they were taken. Specimens taken from deceased patients are included.

The following cases are excluded from the indicator:

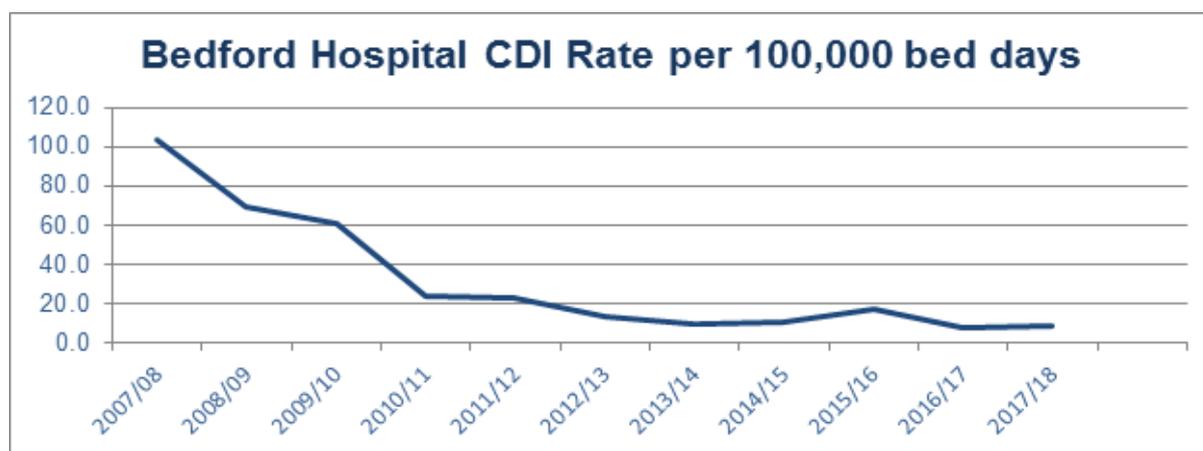
- people under the age of two at the date the sample was taken; and
- where the sample was taken before the fourth day of an admission to the Trust (where the day of admission is day one).

*Table 18: Rate of Clostridium difficile infections*

	2015/16	2016/17	2017/18
<b>Bedford Hospital NHS Trust</b>	17.2	8.25	7.54
<b>England average</b>	14.9	13.2	Awaiting publication
<b>Best performing Trust</b>	0	0	Awaiting publication
<b>Worst performing Trust</b>	66.0	82.7	Awaiting publication

Source: [www.gov.uk/government/statistics/clostridium-difficile-infection-annual-data](http://www.gov.uk/government/statistics/clostridium-difficile-infection-annual-data)

Figure 2: Bedford Hospital CDI Rate per 100,000 bed days



The Trust was set a ceiling trajectory of 10 hospital apportioned cases of laboratory confirmed (GDH positive and toxin positive) cases of clostridium difficile. To date the Trust has been apportioned 11 cases, of which one has been successfully appealed and a further four are awaiting appeal. In all cases there is no evidence to suggest cross infection between patients has occurred, as the ribotyping is different for each specimen. Following a root cause analysis of each case, all cases were designated as being unavoidable and no lapses in care were identified.

Bedford Hospital NHS Trust has continued to implement the following actions:

- Prompt identification and escalation of patients with potential symptoms or at risk of other harms
- Prompt escalation of patients with diarrhoea to the infection prevention and control team
- Prompt isolation of patients standards agreed with the CCG
- Timely specimen collection from the patient
- Utilising an infection prevention and control admission risk assessment form.

Building on the implementation of last year's interventions, additional actions are continuing to reduce CDI cases:

- Working closely with education and training department to ensure compliance with levels 1 and 2 on IPC training
- Working with the CCG infection prevention lead to review the RCA documentation format
- Working with the hospital site management team to ensure that we have a 24 hour rolling programme of assessment and availability of the side rooms within the trust

# Rate of all patient safety incidents and the percentage resulting in severe harm or death

## Domain 5

The rate of patient safety incidents and the percentage resulting in severe harm or death relates to NHS Outcomes Framework domain five: treating and caring for people in a safe environment and protecting them from avoidable harm.

Table 19: Percent of patient safety incidents per 1,000 bed days

	2015/16	2016/17	2017/18
<b>Bedford Hospital NHS Trust</b>	36.2 incidents	39.7 incidents	Not available
<b>National average</b>	39.3 incidents	Not available	Not available
<b>Best performing Trust</b>	18.1 incidents	0.01 incidents	Not available
<b>Worst performing Trust</b>	74.8 incidents	69.0 incidents	Not available

For 2015/16 the data for patient safety incidents resulting in severe harm and incidents resulting in death were presented separately as shown in tables 20 and 21. From 2016/17 the data has been combined as shown in table 22.

Table 20: Percent of patient safety incidents resulting in severe harm

	2015/16
<b>Bedford Hospital NHS Trust</b>	1.2%
<b>National average</b>	0.35%
<b>Best performing Trust</b>	0.017%
<b>Worst performing Trust</b>	2.9%

Table 21: Percent of patient safety incidents resulting in death

	2015/16
<b>Bedford Hospital NHS Trust</b>	0.59%
<b>National average</b>	0.12%
<b>Best performing Trust</b>	0%

<b>Worst performing Trust</b>	0.72%
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Table 22: Percent of patient safety incidents resulting in severe harm or death

	2016/17	2017/18
<b>Bedford Hospital NHS Trust</b>	0.14%	Not available
<b>National average</b>	0.38%	Not available
<b>Best performing Trust</b>	0%	Not available
<b>Worst performing Trust</b>	0.53%	Not available

Notes:

- Bedford Hospital NHS Trust considers that this data is as described for the following reason:

The Trust awaits publication of the data to understand what improvements need to be made.

- Awaiting the data, Bedford Hospital NHS Trust continues take the following action:
- The Trust will continue to review patient deaths through its mortality review group
- Patient safety incidents continue to be uploaded to the NRLS on a weekly basis.
- Incidents resulting in moderate, severe harm and death are validated on a weekly basis through the Datix group meetings and prior to uploading of the data to the NRLS.

## Serious Incidents – reducing patient harm

### Domain 5

Serious Incidents in healthcare are relatively uncommon but when they occur, the NHS organisation has a responsibility to ensure there are systematic measures in place for safeguarding people, property, NHS resources and reputation. This includes the responsibility to learn from these incidents to minimise the risk of them happening again.

'Never events' are a particular type of serious incident that are wholly preventable, where guidance or safety recommendations that provide strong systemic barriers are available at a national level and should have been implemented by all healthcare providers. Each never event has the potential to cause serious patient harm or death (Never Events Framework April 2018).

Bedford Hospital NHS Trust takes this responsibility seriously and is continually strengthening its safety culture to ensure that serious incidents are reported and investigated thoroughly. The Trust reports all serious incidents and never events to Bedfordshire Clinical Commissioning Group and provides an investigation report, outlining the openness and transparency through duty of candour;

root causes of the incident; lessons learnt; and action plans to prevent recurrence of the incident, within sixty working days.

### Serious incidents declared in 2017/18

During the financial year 2017/18, the Trust declared a total of 35 serious incidents compared with 38 in 2016/17.

A breakdown of the categories of Serious Incidents that occurred in 2017/18 is presented in table 24.

Table 24: Categories of Serious Incident that occurred in 2017/2018

Type of incident	Number of Serious incidents
Falls resulting in serious injury	8
Diagnostic incident including delay	6
Baby born in poor condition/transfer out	4
Never Events	3
Complication of procedure	3
Drug Incident	2
Infection control/outbreak	2
Patient deterioration	2
IUD	1
Neonatal death	1
Maternal death	1
Other	1
Total	34

## Safety Thermometer

### Falls

#### Domain 5

In 2017/18 there was one death of a patient that resulted from a fall. In 2017/18 there were eight severe harm falls that were investigated under the SI process. There were four patients that suffered moderate harm.

Falls continue to be measured from reporting harm per 1,000 bed days to allow for fluctuations in hospital activity.

Table 25: Total harm from falls per 1,000 bed days:

	Jan 2016	Jan 2017
<b>Rate per 1000 bed days</b>	2.98	1.24
<b>Number</b>	765	760

NICE guidance CG161 recommends that all Trusts have a Falls Steering Group in place. BHT Falls Improvement Steering Group consists of MDT representation and meets bi-monthly. Several work streams have been identified to address multifactorial elements of at risk patients following recommendations made from the National Falls Audit results (2015 & 2017):

#### Medication review

- Lying/ Standing blood pressure recording/ education for staff
- Vision/ hearing assessment
- Delirium/ dementia assessment

A number of improvement initiatives were developed in-year including:

- Falls prevention week was held in September 2017- leaflets, placemats were distributed to at risk patients highlighting information on reducing risk of falling both at home and in the hospital
- Falls lead visited ward areas to give information and address concerns
- Falls Collaboration Group was formed December 2017. Ten Trusts were included which shared ideas and knowledge. A meeting with learning elements is planned for August 2018
- Enhanced observation pilot project (Baywatch) commenced in Luton and remains in place with positive feedback and the Trust will pilot on high risk wards.

Learning will continue to be shared via:

- Quality Improvement Newsletter and a safety alert specifically relating to the findings of the thematic review
- Quality Board update on cohort / enhanced observation of patient pilot project.

## Pressure Ulcers

Bedford Hospital has strived to continue to maintain standards and improve since the commencement of an improvement program in 2014 to reduce the prevalence of Hospital Acquired Pressure Ulcers (HAPU) and improve wound management.

As part of the Tissue Viability improvement initiatives, we have completed a number of activities outlined below:

- Pressure ulcer risk assessments are monitored monthly by matrons in the nursing quality dashboard. This is reported to the Quality Board and by exception to Quality and Clinical Risk Committee

- A central database tracks all Hospital Acquired Pressure Ulcers (HAPU) and progress against trajectories
- Link Nurses are now established and quarterly study days are attended well.

Multi-disciplinary Diabetic Foot Team has commenced as part of national improvements. We are starting to see evidence in reduction in admissions for people with diabetic foot conditions at BHT – the number of admissions is reduced in the months of Oct – Dec 2017. Those patients with diabetic foot ulcers that are admitted are seen in a timely manner and the tissue viability nurse and diabetic podiatry lead work closely together to ensure appropriate care is provided. We have also introduced a neuropathic foot assessment for all patients with diabetes to be completed on admission. This should see a reduction in preventable ulcers occurring.

After extensive work within the tissue viability service, we have now seen a reduction in incidents of unavailable dynamic mattresses and appropriate escalation to ensure patients receive appropriate equipment in a timely manner.

Collaborative working with the CCG, community and Luton and Dunstable Hospital in regards to wound care and formulary continues. The benefits of the formulary include:

- improving patient outcomes by optimising the use of dressings
- supporting the inclusion of patient factors in decision making about dressings
- improving collaboration between clinicians and commissioners
- improving quality by reducing inappropriate variations in clinical care
- improving quality through access to cost effective dressings
- supporting the supply arrangements of dressings across a local health economy
- supporting financial management and expenditure on dressings across health communities
- supporting practitioners and prescribers to follow guidance published by professional regulatory bodies in relation to dressings and prescribing.

The tissue viability service continues to attend daily quality meetings liaising with seniors and matrons to ensure quick and appropriate communication and escalation of any tissue viability concerns and handover of ward issues to the service.

### **As part of our ongoing work, actions for next year include:**

The tissue viability service has secured study days for wound assessment quarterly for the next financial year for Trainee Nursing Associates, Year 3 Student Nurses, Nurses and Doctors. We will also:

- Commence changes to the investigation process of hospital acquired pressure ulcers to increase timely learning and action
- Test new innovations to reduce harm from pressure.
- Achieve mandatory training compliance of 90 percent
- Introduce best practice/change in practice within chronic leg wounds

# Drug incidents

## Domain 5

There were five serious incidents that involved medication issues in 2017/18. The five incidents were relating to different drugs/themes as follows:

- Out of date allergens being used in an allergy clinic
- Extravasation of sodium bicarbonate 8.4% from a peripheral cannula
- Acute kidney injury following intravenous gentamicin administration
- Omitted doses of desmopressin resulting in hypernatraemia and death
- Furosemide not prescribed in a patient leading to fluid overload

As a result of these serious incidents, the Trust is undertaking the following:

### **Paediatric Allergy Tests**

- Immediate review to ensure no harm to patients and re-testing offered
- Implementation of a protocol relating to the process of allergy testing in paediatrics to include stock management
- Implementation of a contingency plan for actions to be taken during periods of stock unavailability
- Development of an induction programme and training plan/competency assessment for new staff
- Case discussion locally through team and quality meetings; Trust-wide learning through inclusion in the Trust Medication Safety and Quality Improvement Newsletters

### **Extravasation of sodium bicarbonate and tissue damage**

- Case discussion locally through team and Quality meetings; Trust-wide learning through inclusion in the Trust Medication safety and Quality Improvement Newsletters
- Teaching included in Critical Care Complex teaching programme

### **Acute kidney injury following intravenous gentamicin administration**

- Review of Trust antimicrobial guidelines to include the dosing, monitoring and administration of intravenous gentamicin guideline
- Teaching session on therapeutic drug monitoring in FY1 teaching programme
- Case discussion locally through team and Quality meetings; Trust-wide learning through inclusion in the trust Medication Safety and Quality Improvement Newsletters
- Benchmarking compliance with NICE guidance in relation to AKI management

### **Omitted doses of desmopressin resulting in hypernatraemia and death**

- Dissemination of a patients safety alert
- Develop changes to prescribing system to alert staff that a critical medicine has been prescribed but not ordered
- Review and dissemination of critical medicines list

### **Furosemide not prescribed in a patient leading to fluid overload and cardiac arrest**

- Currently under investigation

## Never events

### Domain 5

In 2017/18, the Trust reported three never events.

#### Case 1:

A patient was admitted for elective surgery for a knee replacement. During the surgery one of the instruments broke resulting in a tiny metal fragment being retained in the patient's joint. Appropriate action was taken at the time to look for the metal piece including imaging but this did not identify the retained object. The retained item was identified on post-operative imaging. The patient needed to return to theatre to have the retained metal removed which delayed her post-operative recovery.

#### Learning:

This case highlighted the importance of seeking a second opinion from a surgeon or radiologist if a missing item cannot be seen on imaging at the time of surgery. The case also highlighted safety and the use of loan equipment which was raised with the relevant Company.

#### Case 2:

A patient was admitted for laparoscopic bowel surgery. The procedure was converted from a laparoscopic to an open procedure due to adhesions and bleeding. The surgery was uneventful and the patient was discharged home. The patient was readmitted a month later with signs of an infection. Imaging undertaken identified a retained swab. The swab been retained at the initial surgery a month previously however the swab count checks had been documented as being correct. The retained swab was also evident on post-operative imaging although this was not identified at the time. The patient required a return to theatre to remove the swab and further bowel surgery where the swab was adherent. The patient was discharged home after a lengthy post-operative recovery.

#### Learning:

This case has resulted in the Trust reviewing and strengthening its existing swab counting process and swab count sheet. It has also highlighted the importance of exercising caution when reviewing imaging post operatively to ensure that not only the area of interest is reviewed but that the complete image is considered.

#### Case 3

A patient had a chest drain inserted for a pneumothorax. The clinician performing the procedure failed to remove the guidewire which was not identified at the time of the procedure. A post procedure chest x-ray to check positioning of the chest drain identified the retained guidewire. Arrangements were made with a tertiary centre to have the guidewire removed.

#### Learning:

This case has highlighted the importance of close supervision, training and the use of a dedicated procedure checklist for the insertion of chest drains.

## Complaints

The Trust has a statutory obligation for the handling and consideration of complaints and concerns; to ensure that they are dealt with efficiently, they are properly investigated and that immediate learning and action is taken if necessary. Supporting the formal elements of complaints, the Trust

has a Patient Advice and Liaison Service (PALS) which works with staff, patients, relatives and carers to try and quickly resolve concerns informally and at local service level.

A formal complaint involves a thorough investigation following which the Chief Executive responds directly to the complainant. When investigating a complaint, the Trust is guided by national requirements under the NHS Complaints Regulations and has a local target of 45 working days in which to complete an investigation and respond to the complainant. For the majority of the year complaints have been *responded* to within 35 to 40 working days; this was driven by feedback from complainants who felt they had to wait too long for a response. The Trust is committed to further reduce the response time to 30 – 35 working days by the end of this year.

The Trust offers complainants the opportunity to have access to an independent complaints advocacy service free of charge should they wish to have support through the complaints process.

The Trust endeavours to always provide a timely and satisfactory response to every complaint it receives. However, there are occasions when a complainant may not be satisfied with the response provided by the Trust. The Trust will endeavour to resolve the issues by writing a further letter and/or offering a meeting with the relevant clinicians. If the Trust's further efforts to resolve the issues are deemed unsatisfactory by the complainant, they are advised that they can refer their complaint to the Parliamentary and Health Services Ombudsman (PHSO).

## Overview

- The Trust has seen a downward trend in complaints over the previous years and continues to improve and develop its process in the following ways:
  - Staff training at clinical update
  - Management of concerns through PALS
  - Identify and share themes to inform staff of trends and areas where actions/service improvements can be made
  - 'Look, Listen and Learn' messages for staff are highlighted in the Chief Executive's weekly newsletter

## Parliamentary and Health Service Ombudsman (PHSO)

The Ombudsman's role is to provide an independent complaint handling service for complaints that have not been resolved by the NHS. They investigate unresolved complaints and have the final say. In April 2017 the PHSO came under new leadership; the new Chair is leading modernisation and continuous improvement of the organisation to enable easier access for people to have their complaints about NHS care and treatment resolved. The new leadership has brought about a shift in their scope; they are accepting more cases for investigation and have been noted by the Trust and our neighbouring Trusts to be more critical in their findings.

In 2017/18 the Trust had six complaints referred to the PHSO:

- one complaint was partially upheld because the patient's pain score was not monitored closely, resulting in the patient not being given pain relief quickly enough;
- one complaint was not upheld; and
- four cases remain under investigation.

This compares to the previous year when 16 complaints were referred to the PHSO, of which 12 were not upheld.

### Patient Advice and Liaison Service (PALS)

The Trust's PALS team offers patients and their families or carers a point of contact for any concern, query or any other form of feedback. It can facilitate communication between a patient and the relevant clinical teams. At times, a PALS concern may be escalated to a formal complaint, either as a result of the Trust's process for managing complex issues, or at the patient's request to ensure a more detailed investigation.

In 2017/2018 the Trust registered 656 new formal PALS contacts and resolved 673 concerns.

### Compliments

The Trust is fortunate to receive a significant number of compliments including feedback, thank you cards, gifts and donations. This year the Trust receiving over 4,500 compliments.

Individuals and teams who are named in compliments are included in the weekly staff newsletter as part of our drive to celebrate achievements and successes. The donations category includes both monetary donations to the Trust and donations of equipment. Small gifts, such as sweets and chocolates, are given frequently by patients to staff and are always gratefully received. Any larger gift items are declared to the Trust Board Secretary. The Trust aims to acknowledge each compliment and formally records them on the Datix system.

### Learning from complaints and PALS

- During 2017/18 the Trust introduced an improved process to identify learning to the complainant and staff. Responses from the Chief Executive inform the complainant of changes in our practice as a result of their complaint
- A monthly quality improvement newsletter (QI) is circulated to all staff by email and hard copies are taken to each department by volunteers
- A weekly newsletter from the Chief Executive to all staff highlights 'Look, Listen and Learn' messages from complaints and concerns
- Learning is shared at mandatory staff training at induction, clinical updates and targeted training at ward and departmental level
- The complaints team participate in training staff in root cause analysis, statement writing and giving evidence at coroner's court
- The complaints team participate in regional doctors' training focusing on complaints, claims and statement writing.

Learning from claims is also shared at clinical updates and targeted training at ward and departmental level.

### Next steps

- To sustain and then further reduce the target response time to below 35 working days.
- To improve complainant satisfaction, by showing how their complaint has improved services for other service users. Both of these actions will be monitored by the Complaint Satisfaction Survey.
- Continue to engage with staff to ensure prompt local resolution to respond and further reduce concerns

- Improve patient experience by responding effectively when things go wrong and sharing good practice when patients have a good experience
- To continue to share and embed the learning from complaints/concerns and claims through reporting, training and Trust-wide cultural awareness.

## Friends and Family Test (FFT)

Supporting the information from the annual in-patient survey, maternity survey, children and young people survey, complaints and PALS information and general feedback through listening events, the Trust uses the FFT data. Each patient is surveyed at discharge or following an appointment by either text or paper survey form. FFT data is analysed into two main categories:

- Response rate
- Positivity of response

and these relate to four core service areas:

- Accident and emergency
- Inpatients
- Maternity
- Out patients

The Trust overall receives a response rate that is in line with the national average or above, while the percentage of positivity on average sits within the national range of best practice for A&E and below for maternity and inpatients.

In 2018/19 the Trust will:

- Review the themes within the narrative feedback of FFT comments and align with current training
- Develop a programme of engaging with difficult to reach patients to improve response rates e.g. in the care of the elderly, young people, people with dementia
- Target areas with low response rates.

## National surveys

### **Inpatient cancer survey;**

The national inpatient cancer survey highlighted that patients with cancer feel they need more information during their stay. A working group with key stakeholders meets regularly to implement and drive improvements, particularly focused at speciality level.

### **Maternity survey;**

The main themes identified for improvement were; care in hospital after the birth, specifically;

- Timely pain relief
- Delayed discharge
- Feeding support

The maternity unit has a plan in place to address these themes and has achieved the following;

- Introduction of the maternity safety thermometer
- Delivery of maternity workforce plan supporting the right midwife in the right place at the right time
- Appointment of a Practice Development Nurse
- Improved FFT scores
- Achievement of Baby Friendly re-accreditation

### **Children and young people's survey;**

The main themes identified for improvement were; care in hospital after the birth, specifically;

- Communication across teams
- Communication with patients
- Communication with families/carers

The children's unit has a plan in place to address these themes and has achieved the following;

- Fully established nursing workforce
- Established CAU Nursing Leadership
- Established Medical Leadership
- Multi-disciplinary Safety Huddle
- Engagement in RCPCH SAFE Initiative (Handovers)
- Agreement to recruit a Paediatric Pharmacist

### **Inpatient survey;**

The results from the inpatient survey have not been published by the CQC. The quality strategy for 2018/19 has a strong focus on patient experience, triangulating feedback from multiple sources.

### **Inpatient survey**

Following the national inpatient survey, which concluded in January 2018, regarding different aspects of care and treatment, the CQC weight the results and score them out of 10 to give an average picture across all trusts.

The latest inpatient survey shows that Bedford is 'about the same' in line with NHS Trusts.

13 June 2018

This survey looked at the experiences of 72,778 people who were discharged from an NHS acute hospital in July 2017.

Between August 2017 and January 2018, a questionnaire was sent to 1,250 recent inpatients at each trust.

Responses were received from 429 patients at Bedford Hospital NHS Trust.

Patient survey	Patient response <a href="#">i</a>	Compared with other trusts <a href="#">i</a>
<a href="#">+</a> The Emergency / A&E department answered by emergency patients only	8.5/10	About the same
<a href="#">+</a> Waiting lists and planned admissions answered by those referred to hospital	9.0/10	About the same
<a href="#">+</a> Waiting to get to a bed on a ward	7.2/10	About the same
<a href="#">+</a> The hospital and ward	7.7/10	About the same
<a href="#">+</a> Doctors	8.5/10	About the same
<a href="#">+</a> Nurses	7.5/10	Worse
<a href="#">+</a> Care and treatment	7.8/10	About the same
<a href="#">+</a> Operations and procedures answered by patients who had an operation or procedure	8.2/10	About the same
<a href="#">+</a> Leaving hospital	6.7/10	About the same
<a href="#">+</a> Overall views of care and services	4.2/10	About the same
<a href="#">+</a> Overall experience	7.9/10	About the same

# Quality improvements focused on patient experience

## Real time access to feedback

To enable staff to be more responsive to patient feedback, weekly reports were set up for each ward and department. The reports detailed the current FFT results and comments left by patients.

The inpatient survey results were separated by speciality and distributed to the clinical leads for review and action.

A review of the response rate by patients who use our maternity services has highlighted a low response in two of the four points of contact that patients are asked in the friends and family test question. Maternity has now changed the method of collecting this information, by adding the question to a current survey and also to an app currently used to collect other data.

## Quality improvements

The maternity department have implemented a new care bundle, the obstetric anal sphincter severe tears (OASI) care bundle. The new care bundle has shown a significant reduction in 3<sup>rd</sup>/4<sup>th</sup> degree tears this year.

The maternity department have developed a new guideline to support high risk women to be able to use the birthing pool. There is a strict criterion to keep women and their baby's safe. This work has been recognised nationally and a poster will be presented at the RCM conference. This use of the pool has enabled twins to be born safely in the pool, enabling more women to have the choice of giving birth in the water.

The outdoor play area has been completely revamped and modernised to enhance the delivery of patient care and create a fun and exciting environment to improve experience of young patients whilst on the ward.

A patient from Bedford, who was a patient on Riverbank Ward, joined the hospital's Chief Executive, Stephen Conroy, to officially cut the ribbon to the redeveloped play area.

Riverbank Ward staff initiated a campaign to raise the funds needed to complete this project. Staff completed a number of fundraising activities to kick off the campaign before approaching the Friends of Bedford Hospital Charity who then spearheaded the campaign by generously donating to the fund and recruiting a number of other local individuals and organisations that generously contributed.



The Primrose unit has introduced a new nutritional screening tool, to ensure patients undergoing treatment for cancer are referred to a dietitian early. The tool includes the location of the cancer and the treatment the patient is undergoing.

A new information alert card for patients at risk of metastatic spinal cord compression (MSCC), has been developed by the acute oncology CNS. These cards are handed to all the lung/breast/prostate patients who have bone metastases. It details signs/symptoms of metastatic spinal cord compression and what to do if they have symptoms.

Critical care introduced a new follow up clinic one year ago. The clinic supports patients and their families following discharge, giving them an opportunity to understand what happened to them and why. As the service celebrates its first birthday they have received excellent feedback from patients.

Elizabeth and Harpur wards are re-auditing to continue to keep the Quality Mark successfully. The wards also hosted weekly music therapy for eight weeks. This gave patients with dementia an opportunity to leave the ward and attend the workshop, listening to and joining in with the music therapist. The impact of the therapy is currently being analysed.

### **End of life care**

The Trust has invested in the Gold Standards Framework (GSF) which is a systematic, evidence based approach to optimising care for people in the last year of life with any condition in any setting. GSF focuses on enabling generalists in community and hospital settings to work more effectively with specialists, to care for patients from early identification right through to discharge home or care in the final days. The framework is being implemented on two medical wards.

The pain team have implemented a number of initiatives to improve patient's pain while in hospital. The team lead a group of link nurses who meet regularly to share learning and good practice to take back to their areas of practice. The patient leaflets have been updated for specific conditions and more generally, encouraging patients to ask for pain relief early.

A new method of patient administered pain relief is being trialled in surgery with the aim of reducing the need for intravenous analgesia and inherent risks associated.

### **H&S accreditation**

2017/18 saw the Trust receive the OHSAS18001 accreditation for occupational health and safety and is currently the only NHS Trust in Great Britain that holds this accreditation for an entire hospital site.

The accreditation is a key element in the Trust's Health and Safety Management Strategy. Accreditation will help deliver a structured approach to hazard identification, risk management and put into place a quality agenda based on continuous improvement.

ISO accreditation will support and enhance a healthier and safer working environment in the hospital and potentially contribute to the avoidance of accidents and occupational health problems. This system is proven to enable a business to be proactive rather than reactive when approaching health and safety, therefore more effectively protecting the health, safety and welfare of our workforce on an ongoing basis.

The accreditation recognises the systems and processes developed across the Trust to prevent death, work related injury and ill health to staff and visitors.

### **Baby Friendly accreditation**

The Baby Friendly Initiative is a global programme of UNICEF and the World Health Organisation introduced to improve practice for infant feeding in health care settings. It is a nationally recognised mark of quality care for mothers and babies and it is a status showing commitment for supporting mothers, babies and the complete family unit with infant feeding and relationship building.

Bedford Hospital NHS Trust committed to this programme in 2009 when it was identified that many mothers reported inconsistent advice in relation to infant feeding. Stage one was successfully achieved in 2010 and Stage two in 2013. In 2015 the Trust successfully achieved Stage 3 and became a Baby Friendly Accredited Trust.

Since starting the Baby Friendly programme, the maternity unit has seen a recognised increase of breastfeeding initiation (65% in 2010 and now 82% in 2017- above National average) and more mothers are giving their baby any breastmilk by day 10 (45% in 2013, 60% in 2017). Staff feel confident in the advice and guidance they provide to the mothers accessing our services. Through education and enhanced knowledge, less breastfed babies are likely to be given formula milk, without considering more appropriate options first and the impact of this is more mothers will continue to breastfeed for longer. More mothers are supported to express their breastmilk if a baby is unable to feed directly from the breast and they report a much more positive feeding experience when they receive care to help them manage their expectations and wishes and the advice provided is consistent from all staff members.

In October 2017 the maternity unit was reassessed to ensure that standards have been maintained and families continue to receive the best possible care and to feel fully supported with their feeding options. Of the 30 areas audited, 27 were passed with scores predominantly above 90% (a pass grade is 80%). Following the reassessment, the preliminary report was reviewed by the Baby Friendly Initiative Designation Committee. They accepted the findings and agreed that Bedford Hospital NHS Trust should be reaccredited as of immediate effect, upon the condition that further audits be sent to Baby Friendly within six months to address the three areas where we fell short of the requires 80%. This is such a fantastic achievement and is a credit to the commitment the staff and managers have shown to the programme. At the time of writing this summary report, Bedford Hospital NHS Trust is one of only four Trusts in the east of England to have achieved reaccredited status and in the immediate geographical area, the only other acute area to be at this level is the maternity unit at Peterborough City Hospital.

The assessors were so impressed by the kindness and compassion that staff not only showed to the mothers and infants in their care but to each other as well. The overriding impression gained by the assessment team is that there is a culture of kindness in the unit, with most mothers specifically mentioning this in their feedback. It is seen as a 'beacon' unit within the immediate geographical area.

The aim of UNICEF UK is for the Baby Friendly Initiative standards to become routine practice, to help embed high quality care for the long term - this has been demonstrated in our recent reassessment. Therefore, the focus is now on the Unit working to progress to the 'Gold Award-Achieving Sustainability', which builds on the themes of 'Leadership', 'Culture', 'Monitoring' and 'Progression'. The award will be recognition that the service is not only implementing the Baby Friendly Initiative standards but has the leadership, culture and systems to maintain this over the long time, therefore ensuring that future generations of babies, their mothers and families will still continue to experience the level of care we provide today.

### **Hospital at Home**

The Hospital at Home service is provided by a team of highly skilled specialist nurses that manage a patients acute episode at home under the care of their consultant rather than in hospital. The service's primary aim is to provide high quality patient centred care on a one to one basis adhering to hospital policies and protocols so that patients receives the same care at home as delivered in the hospital setting.

The service strives to promote a "hospitals without walls" ethos so that the transition from hospital to home is a smooth one and limits the patient's length of stay, whilst ensuring a desired health outcome that is consistent with current professional knowledge. The benefits include:

- Quicker recovery time
- Reduces risk of hospital acquired infections
- Comfort of own home
- Good nurse/patient rapport
- Timely administration of medicines
- Improved understanding of diagnosis/treatments
- Reduction in hospital bed costs
- Reduces readmission rates

The team visits around 18 patients per day depending on the level of clinical input required and the patient's geographical location. These patients may require specialised wound care, blood requests and anticoagulation therapy as well as the standard provision of IV antibiotics in order to provide a holistic approach to their care. The service ensures good quality of care using the following principles:

- Ensuring strong leadership that promotes communication between the team and its service users
- Keeping the service patient-focused
- Adhering to a process approach
- Continuous improvement via regular auditing, patient feedback (FFT) and evidence-based decision-making
- Engaging clinicians in the care process to allow them to improve and evolve care over an extended period of time
- Data quality; the correct data, in the correct format at the right time in the right hands
- Adopting a “smart cogs” approach to ensure that the service is driven by clinicians and team members who are highly experienced, educated and committed to exemplary service delivery.

The Hospital at Home team have worked hard to cultivate excellent relationships with hospital consultants, internal departments and external agencies such as the PEPS and the District Nurses and enjoy a close working relationship with AECU and A&E, which enables a speedy turnaround of patients to negate the need for admission. It also enables the staff to react quickly in the event a Hospital at Home patient becomes suddenly unwell.

The service is extremely proud of its 100% positive patient feedback and to be innovating new methods of treatment delivery, such as the use of the elastomeric pump used to deliver QDS medications. In the very near future they will be trained in the implementation of a new brand of Midline (Power Wand) which will not only speed up patient discharges and improve patient experience but will also relieve the pressure on the Vascular Access and Anaesthetics services.

### **NHS Staff Survey results**

The National Staff Survey provides the Trust with key information on how staff experience working in the Trust, what is important to them and where improvements need to be made to enhance their working lives. The response rate for the 2017 survey was 39% (475 staff) which is in the lowest 20% of acute Trusts, the average being 44%; in 2016 the response rate was 41%. The staff engagement score of 3.80 is average across acute trusts.

The report of results provides an analysis of the changes in our scores from the 2016 results. There was one key finding with a statistically significant deterioration since 2016 (in 2016 there were five when compared to 2015):

- % feeling unwell due to work related stress in the last 12 months

There was one key finding with a statistically significant improvement since 2016 (in 2016 there were none, when compared to 2015):

- % appraised in last 12 months

Whilst there is a significant improvement in our performance, which is very positive, the Trust score is below average when compared to all acute Trusts in 2017, indicating that this key finding has

improved across acute Trusts nationally. Overall there was no significant change to the remainder of the key findings from the 2016 survey.

The scores in the best 20% of acute Trusts are:

- % satisfied with the opportunities for flexible working patterns
- % staff satisfaction with resourcing and support
- Effective use of patient/service user feedback
- % reporting most recent experience of harassment, bullying or abuse

The scores in the bottom 20% of acute Trusts are:

- % believing the organisation provides equal opportunities for career progression/promotion
- % reporting errors, near misses or incidents witnessed in last month
- % able to contribute towards improvements at work
- Support from immediate managers

In terms of next steps, the outcomes will be triangulated with other indicators such as patient surveys, sickness absence, turnover and our recent cultural survey to build a fuller picture of what the data is telling us. The results will be broken down by staff groups, divisional and service level to enable a greater understanding of the results.

The results will also be analysed by the demographics of the workforce e.g. race, gender, disability to identify whether the reported staff experience is different for different groups within the workforce.

We will use the analysis of the results and the feedback from staff discussions and stakeholder groups to identify what improvements we need to make. The refreshed Workforce Strategy work-plan for 18/19 will incorporate the actions arising.

The results and actions arising will also be incorporated into the Organisation Development strategy that will underpin the planned merger with Luton and Dunstable University Hospital NHS Foundation Trust.

## Seven Day Services Clinical Standards

Seven day services clinical standards were revised in September 2017. NHS England required four key standards to be met by five hyperacute services by November 2017. NHS Improvement requires the four key standards for other acute services to be met by April 2018 for 50% of the population, extending to 100% of the population by 2020. The four key standards are:

### **Standard 2: time to first consultant review**

All emergency admissions must be seen and have a clinical assessment by a suitable consultant within 14 hours from the time of admission to hospital.

### **Standard 5: diagnostics**

Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, CT, MRI, echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week:

- Within 1 hour for critical patients
- Within 12 hours for urgent patients
- Within 24 hours for non-urgent patients

### **Standard 6: consultant-directed interventions**

Hospital inpatients must have 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols:

- Critical care
- Interventional radiology
- Interventional endoscopy
- Emergency general surgery
- Emergency renal replacement therapy
- Urgent radiotherapy
- Stroke thrombolysis
- Percutaneous Coronary Intervention
- Cardiac pacing (either temporary via internal wire or permanent)

### **Standard 8: ongoing review**

All patients with high dependency needs should be seen and reviewed by a consultant twice daily (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least once every 24 hours, seven days a week, unless it has been determined that this would not affect the patient's care pathway.

### **Results of seven day working – March 2017**

NHS Improvement mandates six monthly data collection on the above four standards. The March 2017 benchmarked data set was published in July 2017; results for standards five and six were based on the Trust's self-assessment.

### **Standard 2: time to first consultant review (14 hours)**

*Figure 3: Proportion of patients who receive a first consultant review within 14 hours of admission to hospital*

**Chart 3: Proportion of patients who received a first consultant review within 14 hours of admission to hospital**



Clinical Standard 2 (time to consultant review) is achievable (and in practice achieved) within current resources in most specialties but this requires improved documentation of the time of the review and/or defined pathways where review is appropriately delegated. However within acute medicine the increased number of admissions in ‘winter’ makes this standard more difficult to achieve. The acute physicians have been asked to develop actions to increase the number of patients seen within 14 hours. One challenge is that only consultants on the specialist register are deemed to be ‘consultants’ for the purposes of this data collection; this excludes a number of locum consultants.

**Standard 8: Daily review of inpatients (twice daily review on acute units) - Figure 4: Daily review of inpatients**

	Day of review							Weekday	Weekend	Total
	Mon	Tue	Wed	Thu	Fri	Sat	Sun			
Once daily reviews required & received	52	47	55	46	51	24	27	251	51	302
Once daily reviews required & not received	12	17	14	20	14	41	40	77	81	158
Excluded from the analysis		1	1	1				3		3
<b>Total number of daily reviews</b>	<b>64</b>	<b>65</b>	<b>70</b>	<b>67</b>	<b>65</b>	<b>65</b>	<b>67</b>	<b>331</b>	<b>132</b>	<b>463</b>
<b>Percentage - Receiving required once daily</b>	<b>81%</b>	<b>73%</b>	<b>80%</b>	<b>70%</b>	<b>78%</b>	<b>37%</b>	<b>40%</b>	<b>77%</b>	<b>39%</b>	<b>66%</b>

**Results of seven day working – September 2017**

**Standard 2**

% patients assessed within 14 hours of admission

- -70 out of 106 patients weekdays (66%). Monday is an outlier with only 54% achieved.
- -23 out of 37 patients weekends (62%)

**Trust actions as of February 2018**

Table 23: Trust actions as of February 2018

Standard	Investment required	Action
2: Time to	No	Develop pathways for delegated care

consultant review		Improved documentation of time of review
5: Access to diagnostics	Yes	Investment required for 7 day access to ultrasound, MRI and echocardiograms (24 hours). 12 hour access would require an on-call or networked service (with outsourcing for MRI reporting). 1 hour access will be difficult to achieve. MRI access planned once new MRI scanner operational
6: Access to intervention/key services	Yes	Investment required into networked interventional radiology service as workforce constraints mean that an STP solution is not feasible. Negotiations underway with tertiary centres around a regional IR service.
8: Ongoing review	Yes	Additional consultant staff required to deliver; daily review of all medically active patients; board round and review or delegated review of all medically optimised patients. Additional middle grade doctors have been appointed to support ward care.

## Proposed merger of Bedford Hospital with Luton and Dunstable University Hospital

In September 2017, the Trust announced new plans to explore a merger between Bedford Hospital and Luton & Dunstable University Hospital to form a single NHS Foundation Trust. This will have one management team and will deliver a full range of services on both sites, providing better care for the populations we serve.

One of the real strengths of this proposal is that the two hospitals already work closely together – and have been doing so successfully for a number of years. Examples of this are specialties such as Neonatal Intensive Care, vascular surgery and stroke services, and others including Ear, Nose and Throat (ENT), Oral and Maxillofacial (OMF), cervical and breast screening services.

As both hospitals serve the populations of Bedfordshire, there is a strong overlap in the catchment areas as well as shared links with commissioners, local councils and ambulance, community and mental health providers. The executive teams and Boards at both trusts strongly believe that a merger between the two hospitals will build and strengthen this existing partnership, encourage expertise to be shared across the two sites, streamline the way that care is provided and remove numerous inefficiencies to ensure that patients have a better experience and improved outcomes.

Importantly, the merger fully supports the work programme of the Sustainability and Transformation Plan (STP) over the last 18 months and will ensure the region can provide more integrated health care for everyone.

Since the announcement, teams from both hospitals have been working closely and at pace to develop a shared vision and to understand what an integrated trust would look like, supported by

BLMK STP partners and national regulators NHS Improvement (NHSI). A Full Business Case, outlining benefits for patients, possible improvements in service provision, opportunities for staff and financial savings, was unanimously approved by both trust boards and submitted to NHSI in December.

Discussions are ongoing with NHSI about the revenue and capital requirements that will underpin the trusts' ability to realise the benefits of the merger, which was originally proposed for April 2018. Both trust boards have committed to reviewing progress in June this year and agreeing the most likely date for the merger to proceed. In the meantime, we will use this additional time to further develop our plans and progress key activity, with priorities being the development of the IT and Pathology functions of the two Trusts.

The merger presents various opportunities such as:

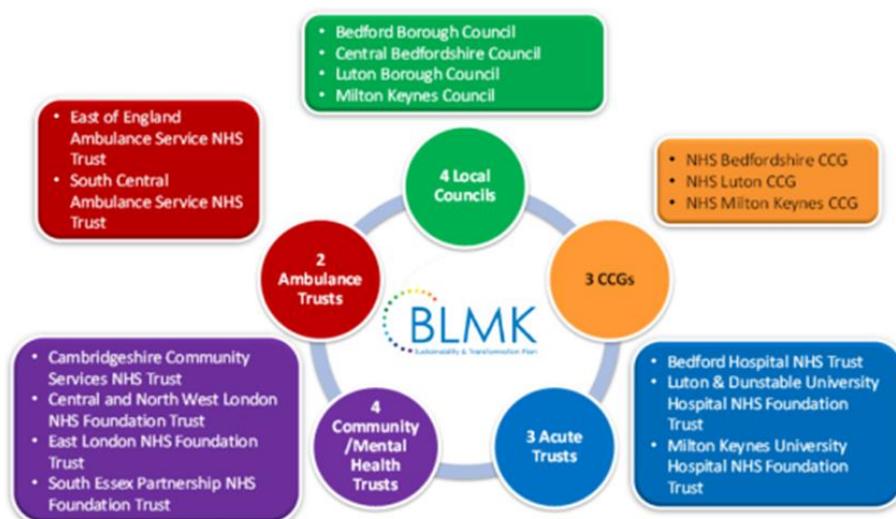
- Enabling more specialities to offer patients a full '7 day' service - this gives better patient care and will help to reduce waiting times
- A more resilient provision of 'on call' and 'out of hours' emergency cover for the expanded population and across all specialties
- Providing certainty for Bedford residents and Bedford Hospital staff after years of speculation about core services being closed
- Increasing opportunities to attract and retain the best staff to a larger, integrated Trust.

## Summary of Bedfordshire, Luton and Milton Keynes (BLMK) Sustainability and Transformation Plan (STP) 2017/18

In 2016, 16 health and social care partners came together to form the Bedfordshire, Luton and Milton Keynes (BLMK) Sustainability and Transformation Plan (STP). The aim of the STP is to support delivery of the 'triple aim' of the NHS Five year Forward View – improved health and wellbeing, transforming

Figure 6: The 16 BLMK STP Partners

The 16 BLMK STP partners



quality of care and financial sustainability.

During 2017/18 work continued to develop transformation in the five priority areas.

1. Prevention – focussing on promotion, healthy lifestyles and
2. Primary, community and social care – the creation and implementation of high quality out of hospital care
3. Secondary care – creating sustainable acute services
4. Digital programme – investing in technology to support future care
5. System Redesign – designing new structures to support the transformation of care (see below)

Bedford Hospital is well engaged within and across the programme, in particular Priorities 3, 4 and 5.

In addition during 17/18 BLMK was designated one of eight national pilot Integrated Care Systems (ICS). This enables the system, with a range of national support offers, to accelerate the development of new models of care, new ways of collaborative working and the testing of new financial flows. This is being led by the Priority 5 workstream. A three tier system is emerging for the future BLMK ICS.

# Statements of assurance from the board

## **Review of services provided by Bedford Hospital NHS Trust**

During 2017/18, Bedford Hospital NHS Trust provided 43 relevant health services and sub-contracted 10 relevant health services. A list of all services provided by the Trust is located in annex one.

Bedford Hospital NHS Trust has reviewed all the data available to it on the quality of care in 100 percent of these relevant health services.

The income generated by the relevant health services reviewed in 2017/18 represents 100 percent of the total income generated from the provision of relevant health services by Bedford Hospital NHS Trust for 2017/18.

# Annex one: services provided by Bedford Hospital NHS Trust in 2017/18

Service Description	
Accident and emergency	Ophthalmology***
Blood transfusion	Oral maxillofacial
Breast Surgery	Orthodontics
Cardiology	Paediatrics
Chemical pathology*	Pain management
Critical Care Medicine (ITU)	Plastic surgery
Dermatology	Podiatry (diabetic outpatients)****
Diabetic medicine	Radiology (includes MRI/CT/ultrasound)
Ear Nose and Throat (ENT)	Rheumatology
Elderly care	Trauma and orthopaedics
Endocrinology	Tunable dye laser treatment
Gastroenterology	Upper gastro-intestinal
General medicine	Urology
General pathology*	Vascular
General surgery	
Gynaecology	<b>Clinical Support Service departments services</b>
Haematology*	Audiology
Histopathology*	Dietetics
Immunopathology*	Orthotics*****
Lower gastro-intestinal	Retinal screening

Medical oncology	Service departments
Microbiology*	Occupational therapy
Midwifery	Pharmacy
Neonatal	Physiotherapy
Nephrology**	Speech and language therapy****
Neurology	Theatres
Obstetrics	Acute admissions unit

\* indicates a laboratory service provided by Viapath

\*\* indicates a service provided by Lister Hospital - East and North Hertfordshire NHS Trust

\*\*\* indicates a service provided by Moorfields Eye Hospital NHS Foundation Trust

\*\*\*\* indicates a service provided by Essex Partnership Trust (EPUT)

\*\*\*\*\* indicates a service provided by Patterson Healthcare

# Annex two: statements from commissioners, Healthwatch and overview and scrutiny committees

## **Central Bedfordshire Council Statement to be included in your Quality Account for 2017/18.**

The Social Care Health and Housing Overview and Scrutiny Committee welcomes the positive journey the Hospital is taking and looks forward to seeing the business plan for merger with the Luton and Dunstable Hospital and the efficiencies it will bring. Looks to see more visible benchmarks for improvement and the Board to look further at ways of reducing the apparent incidents of harassment and bullying of staff.

## Bedford Hospital Quality Account

### Response from Healthwatch Central Bedfordshire

Bedford Hospital serves a significant percentage of the residents of Central Bedfordshire. Healthwatch collects the views, opinions and experiences of Bedford Hospital patients through a range of generic and extensive means including our



website feedback system and through information gathered both at outreach and public consultation and engagement events throughout the authority.

#### RECEPTION



We have noted continued positive responses to improvements in the Hospital's appointment bookings procedures and to keeping to appointment times for planned consultations and procedures.

Many people have also spoken to us positively of the welcoming atmosphere of the Hospital.

We very much welcome the Hospital's priority task of improving patients' experience of end of life care. Although we have noted no adverse comments during the year so far, we will monitor the situation and report on any problems that are reported to us by patients and relatives.

Although Bedford Hospital is not in our local authority area, a large proportion of our residents receive acute care at the Hospital - it is 'their hospital'. It is also the case that the majority of our remaining residents receive their care at the Luton and Dunstable Hospital. As the merger arrangements with the L& D progress, we look forward to working with the teams working on the merger and with the new combined organisation to ensure that the voices of patients living in Central Bedfordshire are heard and acted upon to help improve patient experience and services.



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### **Statement from Bedfordshire Clinical Commissioning Group to Bedford Hospital NHS Trust Quality Account 2017 – 2018**

Bedfordshire Clinical Commissioning Group (BCCG) has received 2017/2018 Quality Account from Bedford Hospital NHS Trust (BHT). The Quality Account was shared with BCCG's Non-Executive director (lead for patient safety), Executive Directors, Performance, and Quality Teams and systematically reviewed by key members of the CCG's Integrated Commissioning and Quality Committee (ICQC), as part of developing our assurance statement.

We have reviewed the information provided within the Quality Account and cross referenced data with data that is submitted to BCCG as part of the Trusts contractual obligation. We have confirmed consistency of data from both sources of information.

BCCG welcomes the Trusts continued commitment to safe effective and well led health care and recognises the Trusts alignment of their new quality improvement strategy with their three year quality strategy which ended in March 2018. The new plan provides clarity on direction of strategy and associated outcomes.

Reviewing the Trusts quality accounts from 2017/18 and the associated priorities, BCCG is aware of how these priorities were formed to align with quality priorities and areas requiring improvement and additional assurance on quality delivery.

Specific priorities regarding improvements in Venous Thrombus embolism (VTE) risk assessment in patients, improving position on number of inpatient falls, improvements in patient experience and feedback and learning from clinical audit align with National Quality strategy expectations and local assurance requirements. As commissioners we are aware of the Trusts requirements following their 2016 CQC inspection and the work that has been put in place to improve specific areas. We know the trust has worked on improving and maintaining dignity for patients and are assured by the ongoing partner's inspections with Health Watch, patient's council and the CCG. BCCG continues to work with BHT on assurances of delivery and ongoing learning for all key priorities.

Throughout 17/18 Bedford Hospital Trust has demonstrated significant improvement in areas regarding patient safety, specifically the Trusts ongoing quality improvement and internal reviews to governance structure with specific focus on serious incident(SI) learning, identifying focus on human factors involved in incidents, delivery of Duty of candour, and detailed RCA (root cause analysis) processes. Development of divisional governance business partners has enabled the governance priorities to flow out into all clinical patient facing areas. We are aware

of the importance of appropriate response when things go wrong in healthcare as a key part of the way that the NHS can continually improve the safety of the services to patients. BCCG recognises the Trusts continued improvement in reducing the number of serious incidents and complaints. As commissioners we continue to work with the Trust on continued improvements to support the reduction in number of incidents and in particular want a focus on reduction in number of never events that cause harm or death. Specifically BCCG recognises the work undertaken over the course of 17/18 to use learning from SIs to transform delivery of maternity services with notable improvements in numbers of mothers initiating breast feeding, and work to reduce the numbers of mothers smoking at time of delivery.

In addition the sustained reduction in the Trusts number of complaints is notable from the previous year and the Trusts Friends and Family test is improved in A&E, inpatients and Maternity services.

BCCG also acknowledges the hard work and commitment of BHT staff over a challenged winter period. We worked closely with nursing operational and medical leaders at BHT to support management of quality patient services delivery in a time when our whole health system was challenged.

Other notable areas of improvement are the work in year around Infection control performance MRSA (Methicillin Resistant Staphylococcus Aureus) and Clostridium *difficile* (C Diff) in particular. The Trust performance supports an improved position for the acute trust which in turn has supported the CCG ranking of 4<sup>th</sup> best in the East of England. The Trust continues to demonstrate strong efforts with clinical teams to remain within ceiling target for Infection control standards

Strategic changes in 16/17 to the pathway for how stroke services were delivered across Bedfordshire has meant a significant change to how care for stroke patients has been provided since. BHT demonstrated a strong commitment to working positively with commissioners and other relevant stakeholders to assure safety and outcomes were consistent for stroke patients who are managed in their care. We continue to work with BHT and primary care colleagues to improve outcomes for patients who present at BHT with Trans Ischaemic Attack (TIA - early warnings of a potential stroke) and are expecting to see the Trust deliver significant improvement in this areas over 18/19 .

BHT demonstrated good participation in National audits and national confidential enquiries. As part of our quality monitoring work with BHT, we will work to understand why specific audits are important to clinical teams. It is very encouraging to see the change in approach to ensure a process for audits which now have Board oversight on actions taken, how the reviews take place and at what level. In particular the learning from the Diabetes clinical audit work has led to significant patient improvements for diabetes care on BHT inpatient wards We welcome the

Trust's commitment to participation in National and local audits and we will continue to provide support to ensure that their service areas use the outcomes of this work to drive further quality improvements.

BCCG recognised the work required to improve data collection and response to collate additional information relating to PROMS for Hip, Knee, and Hernia surgery. We are aware that data collection of these measures are a challenge across many providers and therefore in 18/19 we will work with the Trust on delivering action plans to improve this position.

BCCG acknowledges the Trusts compliance on information governance and is pleased to see the Trust performance against data quality.

We are supportive of the clinical quality priorities the Trust has set for 18/19. We are already aware of the ongoing delivery of improvements in Sepsis under the National CQUIN schemes.

Working with the Trust over 17/18 has enabled BCCG quality team to participate in the Trust led clinical area reviews. BCCG welcomes the continued focus on safety and we look forward to working with the Trust to assure, support and enable achievement of the priorities identified for 2018/19, to continually achieve good quality outcomes for the people of Bedfordshire.



**Sarah Thompson**

**Accountable Officer**

**Bedfordshire Clinical Commissioning**

## Bedford Borough Council

### Adult Services and Health Overview and Scrutiny Committee, 22 May 2018

#### Comment on the Bedford Hospital Draft Quality Account

The Chair welcomed Mr Stephen Conroy, Chief Executive and Ms Liz Lees, Director of Nursing, Bedford Hospital Trust who introduced Bedford Hospital's Draft Quality Account 2017/18. The Director of Nursing provided the following updates:

- There had been some good outcomes regarding the reduction in the number of harms and falls;
- There was some ongoing work regarding sepsis whereby some good outcomes for patients in terms of infection prevention and control had been managed well, particularly during the hard winter months, and that Bedford Hospital was well below its c-difficile trajectory for the year;
- Good improvements had also been identified within Maternity Services;
- Additional pledges had been signed up to regarding safety as had the commitment of the hospital to provide good patient care being a priority for 2018/19;
- Good participation in both local and national audits had taken place; and
- Some further work was required regarding staff, improving feedback from patients, visitors and carers to help shape services in the future.

In response to Members' questions and comments, the Chief Executive and Director of Nursing, Bedford Hospital Trust provided the following responses:

- It was acknowledged that there had been an increase in some emergency re-admissions and Bedford Hospital was working with its' partners and local health providers to reduce these incidents – it was also a target for 2018/19 to reduce the number of emergency re-admissions to the hospital;
- A reduced level of engagement with staff was a cause for concern and it was possible this was linked ~~with the~~ merger with Luton and Dunstable Hospital. Whilst staff engagement was currently above the national average, a reduction in staff engagement levels had been identified during the last three years. It was suggested that when a date for the merger had been identified, staff engagement levels would improve. It was also noted that there was significant enthusiasm for the merger;
- The last staff survey had been of a random email targeted group, therefore a wider staff engagement piece of work would be undertaken in the future;
- The Commissioning for Quality Innovation (CQUIN) framework, Indicator 1A referred to the amount of sugar and drinks on sale within the organisation,

and not all of the components had been achieved. The hospital was currently in Year 2 of the CQUIN framework which sought to ensure healthy options were available to its staff;

- The Urgent Treatment Centre would seek to relieve some of the increasing pressures being experienced at the Accident and Emergency Department. The Urgent Treatment Centre had been designed with clinicians, A&E staff and GPs at the Cauldwell Medical Centre in order to provide an integrated service across both departments; and
- In relation to the hospital merger proposal, due to changes in the timetable, business cases would not be considered until the beginning of July, therefore it was unlikely that the capital requirements for the merger would be known by June as originally planned. Outcomes of the capital bids would become known in October.

Members concurred that it was a particularly encouraging report and that a lot had been achieved within the last twelve months.

RESOLVED:

- i) That the progress at Bedford Hospital NHS Trust be noted.
- ii) That the following comments on Bedford Hospital NHS Trust's draft Quality Account for 2017/2018 be noted:
  - the Trust's priorities matched those of the public;
  - no major issues had been omitted by the provider;
  - the Trust had demonstrated that patients and members of the public had been involved in the production of the draft Quality Account; and
  - there were no comments on issues the Overview and Scrutiny Committee was involved in locally.
- iii) That the Committee's comments, in the form of a minute extract, be provided to Bedford Hospital NHS Trust for publication in its Quality Account.
- iv) That Mr Stephen Conroy, Chief Executive and Ms Liz Lees, Director of Nursing, Bedford Hospital be thanked for their attendance.

25<sup>th</sup> May 2018

Dear Stephen,

**Bedford Hospital - Quality Account (QA) 2017/18**

**Comments from Healthwatch Bedford Borough (HBB)**

HBB are pleased to have been able to peruse this very comprehensive QA. The detail within speaks volumes in regards to your commitment to provide a high standard of patient care and your continued dedication to ensuring patient safety is at the forefront of everything you do.

We recognise that these are uncertain times for the NHS, but are encouraged by the amount of work undertaken by Bedford Hospital NHS Trust this past year.

HBB are firstly pleased to see the percentage improvement in FTT scores for Inpatients, Maternity and Accident and Emergency. Along with comments made to us, this shows that BHT is very respected by the local population.

Within your Quality Improvement priorities, the time allocated to the training, diagnosis and subsequent treatment of Sepsis shows your dedication in being able to facilitate the early recognition and appropriate treatment of sepsis, in order to maximise survival.

HBB is encouraged by the implementation of 'The Gold Standards Framework for End of Life Care' and is hopeful that by rolling out this evidence based approach, you will increase effectiveness across acute & secondary care for patients on their final journey.

Having looked at your 'Learning from deaths' report, whilst HBB are saddened that one of the 561 deaths during the period was judged to be more likely than not to have been due to problems in the care provided to the patient, we are satisfied that you have learnt from case record reviews and investigation outcomes. We hope that this crucial learning is carried forward and documentation improved.

Whilst studying the 'percentage of staff who would recommend the Trust to friends and family needing care', we are disappointed to see the drop from 2015/16, and the disparity between Bedford Hospital NHS Trust's figures and those

of the national average, however we recognise the challenging times that you have faced and the uncertainty for staff in relation to funding for the proposed merger into a foundation Trust. HBB feel it would only be right to take these problematic delays into account and wish you well moving forward in relation to this.

HBB must greatly congratulate you on your reduction in reported C.Diff cases for 2016/17. Your commitment to reduce the rate of CDI's from 17.2 (2015/16) to your current figure of 8.25 shows outstanding assurance to the local population on your staff's dedication to providing a safe environment and protecting them from harm.

In summary, HBB thank you for allowing us the opportunity to be able to comment on the Quality Account 2017/18 and wish you all well with the year ahead.

Yours Sincerely,



Chair, Healthwatch Bedford Borough

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*“A strong voice for local people”*

# Annex 3: statement of directors' responsibilities

## Annex 3: statement of directors' responsibilities

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended by the National Health Service (Quality Accounts) Amendment Regulations 2011 and the National Health Service (Quality Accounts) Amendment Regulations 2012)).

In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

- the Quality Accounts presents a balanced picture of the Trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health guidance.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

By order of the Board

Chair:

  
GORDON JOHNS

Date: 24.5.18

Chief Executive:

  
STEPHEN CONROY

Date: 24.5.18

# Annex four: external audit limited assurance report

## INDEPENDENT AUDITORS' LIMITED ASSURANCE REPORT TO THE DIRECTORS OF BEDFORD HOSPITAL NHS TRUST ON THE ANNUAL QUALITY ACCOUNT

We are required to perform an independent assurance engagement in respect of Bedford Hospital NHS Trust's ("the Trust") Quality Account for the year ended 31 March 2018 ("the Quality Account") and certain performance indicators contained therein as part of our work. NHS trusts are required by section 8 of the Health Act 2009 to publish a Quality Account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 ("the Regulations").

### Scope and subject matter

The indicators for the year ended 31 March 2018 subject to limited assurance consist of the following indicators:

- Percentage of patients risk-assessed for venous thromboembolism (VTE); and
- Rate of clostridium difficile infections.

We refer to these two indicators collectively as "the indicators".

### Respective responsibilities of the Directors and the auditor

The Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the Regulations).

In preparing the Quality Account, the Directors are required to take steps to satisfy themselves that:

- the Quality Account presents a balanced picture of the Trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health guidance.

The Directors are required to confirm compliance with these requirements in a statement of directors' responsibilities within the Quality Account.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance ("the Guidance"); and
- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

We read the Quality Account and conclude whether it is consistent with the requirements of the Regulations and to consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Account and consider whether it is materially inconsistent with:

- Board minutes for the period April 2017 to May 2018;

- papers relating to quality reported to the Board over the period April 2017 to May 2018;
- feedback from the Commissioners requested 14 May 2018;
- feedback from Local Healthwatch requested 14 May 2018;
- the Trust's most recent complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009, dated April 2018;
- feedback from other named stakeholder(s) involved in the sign off of the Quality Account;
- the latest national patient survey dated 2018;
- the latest national staff survey dated 2017;
- the Head of Internal Audit's annual opinion over the Trust's control environment dated 22 May 2018;
- the annual governance statement dated 22 May 2018;
- the Care Quality Commission's Intelligent Monitoring Report dated 20 April 2016; and

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with these documents (collectively the "documents"). Our responsibilities do not extend to any other information.

This report, including the conclusion, is made solely to the Board of Directors of the Trust.

We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and the Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

#### **Assurance work performed**

We conducted this limited assurance engagement under the terms of the Guidance. Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content of the Quality Account to the requirements of the Regulations; and
- reading the documents.

A limited assurance engagement is narrower in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

#### **Limitations**

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

The nature, form and content required of Quality Accounts are determined by the Department of Health. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by the Trust.

### Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the Guidance; and
- the indicators in the Quality Account subject to limited assurance have not been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

*KPMG LLP*

KPMG LLP  
Chartered Accountants  
15 Canada Square  
London  
E14 5GL  
25 June 2018

# Annex five: acronyms and abbreviations

A&E	Accident And Emergency
AAU	Acute Assessment Unit
AKI	Acute Kidney Injury
ALERT	Acute Life Threatening Events Recognition And Treatment
ALS	Advanced Life Support
BAETS	British Association of Endocrine and Thyroid Surgeons
BEACH	Bedside Emergency Assessment Course For Healthcare Assistants
BLS	Basic Life Support
BNP	B-Type Natriuretic Peptide
BTS	British Thoracic Society
CAP	Community Acquired Pneumonia
CAU	Children's Assessment Unit
CCG	Clinical Commissioning Group
COPD	Chronic Obstructive Pulmonary Disease
CPD	Continuing Professional Development
CQC	Care Quality Commission
CQUIN	Commissioning For Quality And Innovation Payment Framework
CTG	Cardiotacography
DAHNO	Data For Head And Neck Oncology
DNACPR	Do Not Attempt Cardio Pulmonary Resuscitation
DVT	Deep Vein Thrombosis
ED	Emergency Department
ENT	Ear, Nose And Throat

EPR	Electronic Patient Record
FFT	Friends And Family Test
FIGO	International Federation of Gynaecology and Obstetrics (Fédération Internationale de Gynécologie et d'Obstétrique - FIGO)
GMC	General Medical Council
GP	General Practitioner
GRS	Global Rating Scale
GUM	Genitourinary Medicine
HHS	Hyperosmolar Hyperglycaemic State
HPA	Health Protection Agency
HNA	Holistic Needs Assessment
HSCIC	Health And Social Care Information Centre
HSE	Health And Safety Executive
HSMR	Hospital Standardised Mortality Ratio
IBD	Inflammatory Bowel Disease
ICNARC	Intensive Care National Audit & Research Centre
ILS	Immediate Life Support
IOL	Induction of Labour
ISO	International Organisation For Standardization
JAG	Joint Advisory Group
MHRA	Medicines And Healthcare Products Regulatory Agency (MHRA)
MINAP	Myocardial Ischaemia National Audit Project
MRSA	Methicillin-Resistant Staphylococcus Aureus
NACR	National Audit For Cardiac Rehabilitation
NAS	Neonatal Abstinence Scoring
NASH	National Audit Of Seizure Management
NBOCAP	National Bowel Cancer Audit Programme

NCDHAH	National Care Of The Dying
NCEPOD	National Confidential Enquiry Into Patient Outcomes And Death
NCRN	National Cancer Research Network
NELA	National Emergency Laparotomy Audit
NEWS	National Early Warning System
NHFD	National Hip Fracture Database
NICOR	National Institute for Cardiovascular Outcomes Research
NHS	National Health Service
NICE	National Institute For Health And Care Excellence
NIHR	National Institute For Health Research
NIV	Non-Invasive Ventilation
NJR	National Joint Registry
NMC	Nursing And Midwifery Council
NNU	Neonatal Unit
NRLS	National Reporting And Learning System
NT	Neural Tube
PACC	Professional Association Of Clinical Coders
PALS	Patients' Advice And Liaison Service
PAR	Patient At Risk
PCA	Patient Controlled Analgesia
PCNL	Percutaneous Nephrolithotomy
PHSO	Parliamentary And Health Service Ombudsman
PHP	Personal Health Plans
PLACE	Patient Led Assessment Of Care Environments
PPC	Post-Operative Pulmonary Complications
PREP	Post-Registration Education And Practice
PROM	Patient Reported Outcome Measure

PTWR	Post-Take Ward Round
QRS	Quality Review Scheme
RAG	Red, Amber, Green
RAM	Risk Adjusted Mortality
RCA	Root Cause Analysis
RCEM	Royal College of Emergency Medicine
RCR	Royal College of Radiology
RBC	Red Blood cell
SHMI	Summary Hospital-Level Mortality Indicator
SHO	Senior House Officer
SSNAP	Sentinel Stroke National Audit Programme
SSRI	Selective serotonin reuptake inhibitor
TARN	Trauma Audit And Research Network
TDA	Trust Development Authority
TEP	Treatment Escalation Plan
UNICEF	United Nations Children's Fund
VBAC	Vaginal Birth After Caesarean
VTE	Venous Thromboembolism
WHO	World Health Organisation
WTE	Whole Time Equivalent

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