#

# BEDFORD HOSPITAL QUALITY ACCOUNT 2019/20

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## Part one: Statement on quality from the joint medical director

I am delighted to introduce the Bedford Hospital Quality Account for 2019/20 which becomes the last of its kind due to our merger with the Luton and Dunstable University Hospital that took place on 1 April 2020 to form one single large organisation, Bedfordshire Hospitals NHS Foundation Trust.

In face of what has been another exceptionally busy year for the NHS, our staff have worked incredibly hard to make sure that the standards of care provided to our patients have not dropped.

Our hospital has seen consistently higher attendances often with lower than expected discharges, which in some part reflects the growing and changing care needs. Bedfordshire has one of the oldest populations in the country, and it continues to grow at a rapid rate. This places an inevitable demand on our services and we now need to be more responsive to long-term conditions as well as the necessary acute interventions.

Our continued delivery of safe care for patients is only possible with the dedication and compassion of our outstanding staff working to treat patients with increasingly complex conditions. Even with this increase in demand, considerable improvements in the quality of care, the Trust provided were achieved. You will see from the data some of our improvements which include:

* Our Support Services team being reaccredited with the Customer Service Excellence quality mark for 2019. The Customer Service Excellence (CSE) standard encourages organisations to focus on the individual needs and preferences of the service users. The CSE mark is held by a select group of organisations and we are one of only 4 NHS Trusts to have achieved this.
* Achieved consistently low infection rates, with Clostridium difficile infections remaining the below the national standard.
* Our Endoscopy Department was JAG reaccredited for 2019. The team successfully met all the criteria set out in the JAG standards without any complications or caveats.
* We were delighted to be one of 78 Trusts to receive funding to upgrade screening equipment to improve cancer diagnosis and survival. The funding was part of the Government’s £200m funding injection to upgrade cancer testing and detection technology. Two new MRI scanners and a new CT scanner were some of the equipment purchased with this funding.

As we continue to travel through unchartered territory, responding to the greatest health emergency in NHS history, it has been remarkable to see how well, all health and social care staff have responded to the COVID-19 pandemic. I’d like to take this opportunity to thank everyone across the organisation, who continues to work under immense pressure in these challenging times, the care and commitment we see every day is really humbling.

Whilst we maintained our strong performance against the national cancer care waiting time standards where we have consistently performed above the national average in many areas we were not able to meet the four-hour A&E access standard or the 18-week referral-to-treatment waiting time target. Although some of our operational performance targets have dropped our infection control measures remain strong, with only 1 MRSA case and 10 Clostridium Difficile cases, below our ceiling of 11.

One of the most notable highlights of 2019 was the confirmation that the request for capital funding needed for the proposed merger with the Luton and Dunstable University Hospital had been approved and allocated. As soon as this confirmation was received from the Department of Health and Social Care our plans were reinvigorated, kick starting the incredible hard work and dedication from staff on both hospital sites to achieve one single Foundation Trust by April 2020.

The hard work of our ambitious plans paid off as we officially started our journey as Bedfordshire Hospitals NHS Foundation Trust on 1 April, as planned. The merger is incredibly important for our local health economy, but understandably COVID-19 activity has been our priority both locally across our two hospitals and for the entire NHS. Providing consistent leadership within an integrated Trust is essential as we operate through these unprecedented times. The merger will no doubt help us in building a more resilient workforce, working together as one Trust to provide the best care for our patients in very difficult circumstances.

The new integrated Trust will bring together a combined workforce of approximately 8,000 staff and is the largest NHS employer in Bedfordshire - caring for a population of approximately 620,000 people. Each individual hospital will retain their name and proud heritage along with continuing to deliver a full range of services on both sites. This includes retaining key services such as A&E, Obstetrics-led Maternity and Paediatrics at Bedford.

The creation of one Trust Board has always been part of the merger plans and as such we’ve sadly said goodbye to some senior executives including our Chief Executive, Stephen Conroy who provided valuable, high quality leadership for nine years at Bedford Hospital. David Carter (previously CEO at the L&D) now takes up the CEO role at the new Bedfordshire Hospitals NHS Foundation Trust and will lead the way for next year’s Quality Account. I am sure you will all join me in wishing colleagues both new and old as well as the organisation all the very best for the future.



**Paul Tisi**

Joint Medical Director

Bedfordshire Hospitals NHS Foundation Trust

## What is a Quality Account?

All providers of NHS services in England have a statutory duty to produce an annual Quality Account. This is a report that informs the public about the quality of the services that we deliver. They are published annually and are available to the public.

Quality Accounts aim to increase public accountability and drive quality improvement. They do this by requiring organisations to review their performance over the previous year, publish their performance and identify areas for improvement. Quality Accounts will also inform you about how an organisation will make those improvements and how they will be measured.

A review of our quality of services for 2019/20 is included in this account alongside our priorities and goals for quality improvement in 2020/21 and how we intend to achieve them.

## Part two: Looking Back: A review of 2019/20 quality improvement priorities

**This section reviews the Trust’s actions and performance against its 2019/20 quality improvement priorities.**

Following consultation with staff, stakeholders and patient organisations, the Trust identified three key quality priorities for 2019/20 against quality indicators:

* Improve patient documentation, both the quality and access to patients notes - patient safety
* Speeding up diagnosis of cancer - clinical outcomes
* To improve communication and understanding, that patients have about their care and treatment - patient experience

### Patient safety priority – GDE (Global Digital Exemplar)

Improve patient documentation, both the quality and access to patients notes by implementing the following;

* Digitisation of paper patient records through an on-site scan centre and implementation of an electronic document record management system (EDRMS).
* Patient records are now beginning to be scanned by the Bedford Xerox Scanning Bureau who took over the management of paper health records in November 2019. This creates a digitised record which will be available to all clinicians across Bedford Hospital via the MediViewer software.
* Clinicians are being trained in MediViewer via a mixture of face to face and online learning.
* The process of scanning will be ongoing for a period of time but it is progressing at pace, following a rollout schedule agreed with clinical and operational leaders. As stated below, new patients to the hospital will be managed with digital records.
* All activities / measures listed below have been scheduled for 2020-2021.
* *Planned for June 2020*: introduction of MediViewer; when fully implemented this will eliminate handling of paper Health Records by clinical staff and provide simultaneous instant access by staff.
* *Planned for June 2020*: Fully managed scanning bureau; Scanning the entire patient record and handling on-going paper generation using interim barcoded ‘smart forms’ that are available following an outpatient clinic in MediViewer,
* Elective/planned Clinics will have health records digitally scanned in advance and accessible in MediViewer throughout the contract term,
* New patients to the Trust will be given a new digital Health Record,
* Emergency access to records will be managed and provided in a timely fashion.
* Ongoing process of integration with Clinical Systems; MediViewer will allow users to pull key information held in key Trust clinical systems quickly and efficiently, streamlining clinical pathways and facilitating higher levels of care in shorter time frames,
* *Planned for 2021*:  full roll out of MediViewer, eForms contributing towards direct entry of clinical information directly into MediViewer, saving clinical time.

**Improvements to patient care:**

Patient notes are available any time and any place to clinicians who require them. This will reduce delays and cancellation due to unavailability of patient notes.

Digitised notes are organised and indexed in a way that makes is easy for the clinician to find relevant information quickly.

#### Redevelopment of the electronic discharge process to reduce time taken to complete paperwork, increase accuracy of data and integrate directly into local primary care systems.

Electronic discharge letters which will be transferred digitally into GP records are in the implementation phase. Due to the complexity of the technology involved this has been a time consuming project. Bedford Hospital aims to achieve full implementation of this functionality by the end of 2020.

Development is underway to implement a new electronic discharge system for day-case patients and inpatients which should improve timeliness and accuracy of information in discharge letters.

Extensive testing of the new functionality is under way aiming for rollout of the new functionality in December 2020.

**Improvements to patient care:**

Key discharge information is available to clinicians in primary and community care settings immediately. If a patient presents in primary care after being discharged from hospital the information pertaining to the hospital stay will be there.

#### Implementation of a clinical portal that pulls data from disparate trust systems into one place providing a quick and holistic overview of a patient’s digital record.

* The Portal is live and available to all clinicians across Bedford Hospital.
* Live: Use of a single logon improves access times and frees up clinical time – providing a reduction in time spent to access information resulting in increased time spent on patient care,
* Live: Clinical staff now have access to information to support MDTs and integrated care – providing a centralised high level view of a patients record to support clinical pathway and collaborative work between multi-disciplinary teams,
* Future Phase: Planned provision of access to Primary/Community/GP Care records - Improvement in patient flow across the Trust.

**Improvements to patient care:**

This presents patient information that that has historically been held in disparate systems in one view and one login.

Reduction in time spent by clinicians searching for information in different systems.

#### The launch of a digital communications platform within the trust enabling video calls, instant messaging, file sharing and improved communication internally and with other organisations.

To assist with the increased level of remote-working; Microsoft Teams has now been implemented for all staff at Bedford, enabling staff to collaborate in one central, secure location.

* Several changes to the telecommunication system are being made to improve the service and the end users experience with the objective of
* Rollout voice over IP phones throughout the Trust
* Rollout of Microsoft Teams functionality across the Trust

**Improvements to patient care:**

The technology supports improved communication between clinicians and improved cross site working. The use of collaboration tools ensures clinical expertise is shared and available where needed, which does have a direct impact on patient care.

#### Implementation of a new A&E system for patient flow management that is integrated with key clinical systems for orders & results and alerts from the NHS Spine (e.g. child protection alerts).

The Symphony Emergency Department system went live in November 2019. Symphony replaces the use of paper (CAS cards) to record patient attendance information. A&E patients are now registered in Symphony and all patient information electronically captured in Symphony. There are now no paper records at patients’ beds; instead staff are updating information on computers and laptops directly.

* By automating processes and capturing patient attendance information electronically, A&E staff have immediate digital access to crucial patient information at the point of care thereby improving patient safety and care and departmental efficiency.
* Symphony is also interfaced with the hospital’s PAS and ICE (orders and results) systems for better patient management.
* Symphony’s connectivity with the NHS spine for Child Protection Information System (CPIS) service went live end of March 2020.

This will allow local authorities and the Trust to share child protection information securely and help identify and protect children who arrive at A&E.

The implementation of Symphony enabled more effective nursing documentation which supported more valuable auditing of notes, patient outcomes etc.

Symphony also supported clarity of recording outcomes of four hourly intentional rounding.

**Improvements to patient care:**

Emergency Department (ED) staff have real-time access to crucial patient information at the point of care, thereby improving patient safety and care and departmental efficiency.

Real time patient management supported by Symphony will support the hospital reaching four hour waiting targets

Symphony has enabled improvements in the speed and accuracy of data capture during an attendance. As a result patient records are more accurate and comprehensive, supporting future clinical decision making and cannot be misplaced.

### Clinical outcomes priority

Speeding up diagnosis of cancer by implementing the following;

**Increasing clinical nurse specialist in colorectal specialty to implement the straight to test pathway (STT)**

The implementation of the STT pathway in colorectal will reduce the amount of time the patient needs to wait for a cancer or non-cancer diagnosis.  The patient will not need an outpatient appointment first, they will be triaged over a telephone for suitability and then booked in for the colonoscopy within 10 days.  We received funding from the Cancer Alliance to increase our nurse establishment and we currently have one nurse in post with a further nurse commencing in March.  We started the pathway in February 2020 and it is going well, but it is too soon to judge what effect it has had on the pathways.

**Pilot for suspected lung cancer patients to access computed tomography scan (CT) and outpatients (OPD) on the same day**

One stop clinics for CT and OPD are currently in place for our lung cancer pathway and working very well.  The reason for implementing this was to ensure that when the patient attends their first OPD, the scan had been completed and the majority of patients, can have cancer ruled out at that first appointment.  The one stop also speeds up the pathway for patients who may have lung cancer as their first diagnostic test has been carried out before being seen.  This has reduced the pathway for our lung cancer patients.  Further changes to clinics are being made in March which will include one stop appointments within all of the Consultant clinics.

**Gynaecology patients to have ultrasound scan (USS) before OPD**

The reasoning behind this is very similar to the lung pathway as the majority of patients would require an USS after they have had their first appointment.  With the USS being carried out before they are first seen, we can reassure a lot of women that they do not have cancer at their first appointment, but it also reduces the pathway for those women who are diagnosed with cancer.  This has also worked very well and has reduced a lot of anxiety for patients as they can be reassured a lot earlier.

**Continue with Breast one stop clinic**

The Breast one stop clinics works incredibly well with the majority of people being discharged after only one visit to the hospital.  It also means that for the people who are to continue down the cancer pathway, the majority of their tests are done on that very first day so their time to treatment is reduced.

**Review all cancer specialties to reduce waiting for diagnostics**

All of the cancer pathways are being reviewed to try and reduce the time to diagnosis for every patient.  As well as the pathways above, we have also implemented ‘straight to test’ multi-parametric MRI for Prostate Cancer patients which has worked very well and reduced the wait time for a high number of patients.

‘Straight to test’ oesophago-gastroduodenoscopy (OGD) is also in place for the Upper gastro-intestinal (GI) pathway and we have just recruited a nurse who will monitor these patients and ensure that there pathway is smooth and timely, we are also working on a process with Radiology to ensure that any patient who has an abnormal OGD has their CT within 3 days.

### Patient experience priorities

Improve communication and understanding,that patients have about their care and treatment by; holding more patient experience and listening events to fully understand the patient experience and learn where we can make improvements

This approach enables the Trust to obtain qualitative information that compliments feedback from national and local surveys that is generally quantitative.

Three listening events have been held during this period.

1. A&E patients. March 2019
2. Prostate cancer patients – February 2020
3. Carers

**Carers -** This was attended by trust staff, PALs and Carers in Bedfordshire. Several Patients provided their experience of being a carer and two carer’s experiences were further reviewed as complaints. One of these complaints was about cancer patient, this information was shared with cancer service managers and related to the national cancer services patient survey outcomes.

**A&E -** A team of A&E staff, PALs team and other senior nurses met several patients that had attended A&E recently and shared their experience. Generally positive feedback, one patient highlighted experience in missed fracture, the A&E Registrar present followed the issues through from her experience. The outcomes from this event were fed back to Trust board in a patient story.

**Prostate Cancer patients** – this event was targeted at patients undergoing diagnosis and treatment in the Prostate cancer pathway. 70 patients were sent invitations, with 12 patients attended. Feedback for this event is being collated at time of this report. The cancer division will use this feedback to review their recently implanted revised pathway.

**NHSi Patient Experience Improvement Framework** - This event was attended by multi-disciplinary and multi-agency staff to gather feedback and ideas to formulate the Trust Patient Experience and Engagement Strategy. The strategy was written during 2019 and finally approved at Trust Board in 2019. Following approval of this strategy a quarterly progress report is being provided to the Quality board.

**Reviewing all patient appointment letters to ensure that they are clear and understandable to our patients** – the trust tailored appointment letters to make it more responsive and service-identifiable (e.g. one for physio, one for specialist nurse).

**A revised process for providing patient stories to Trust Board in Q 2 -** The Board were provided with a brief report about patient experience, to set the context of patients experience and outline the service concerned. This enabled the time to present the story for patient to be maximised and for Board members to consider questions they may like to ask in advance.

Bedford HealthWatch supported a review of the children’s service areas, provided a report and were invited to present their findings to the Trust board. A local action plan was devised to address the issues identified from their visit.

### Overall contribution to patients safety / experience

Conducting the above workshops and listening events has been a valuable learning experience for those involved. The learning and experience will support the provision and use of these events in 2020/2021 following Trust merger with L&D

A new Trust website went live on 1 April 2020 and will go through continuous development as content is updated following the merger. It currently adheres to the new Government legislation for Accessibility Information Standards. The deadline for all public sector websites to achieve this standard is 21 Sept 2020 which we have met.

Top 9 patient leaflets have been translated into the top 3 local languages (Italian, Polish and Punjabi) however our recent maternity leaflets explaining changes due to COVID have been translated in to the top 6 languages in Bedford and Luton (Polish, Italian, Romanian, Urdu, Bengali and Punjabi)

As a newly merged organisation, going forward we will be translating the most common Trust wide leaflets into the above 6 languages.

## Looking Forward - Quality improvement priorities for 2020/21

**This section sets out the Trust’s quality improvement priorities for 2020/21. It details our plans for each priority, how we will report and measure our progress and sets out our measures of success.**

In setting the priorities for 2020/21, the Trust reflected that the priorities would be taken forward by the newly merged Trust and would sit across both intended sites. In addition, with the increase in CQUINs (nationally mandated quality standards), the priorities should reflect those.

The priorities for the coming year are drawn from the quality strategy of the Luton and Dunstable quality improvement plan. The quality priority works streams are aligned with the Trusts four main quality priorities;

* to deliver excellent clinical outcomes,
* to improve patient safety,
* to improve patient experience and
* to prevent ill health.

The diagram below describes each of the priorities under these headings together with a rationale for their inclusion, how we will measure success and how we will oversee the progress we make throughout the year. Whilst we have identified priorities for 2020/21, the future is currently uncertain so we may seek to review and reprioritise as the year progresses and as we continue to respond to the global COVID-19 pandemic.

* There is established NICE and PHE guidance for appropriate diagnosis and management of UTI. Improving diagnosis and treatment will reduce treatment failure, risk of healthcare associated bacteraemia and reduce associated length of stay.
* In 2016/17, more than 50,000 liver admissions nationally were unplanned and avoidable. Improved cirrhosis testing will increase the number of liver disease diagnoses, the aim of which is to change patient behaviour in time for more effective treatment and better prospects of recovering supporting a reduction in the burden that liver disease places on the NHS.
* Staff flu vaccines are crucial for reducing the spread of flu during winter months, with a significant impact on the health of patients, staff, their families and the overall safe running of NHS services.
* This work will continue to build upon work started in 2019/20 to improve discharge planning and implementation for patients. Over 2019/20, there was a reduction in the number of complaints and concerns around discharge but a number of work streams had been identified and need further work to embed improvements. Furthermore, changes to the Trust structure, afforded by the merger, means that there is opportunity to expand upon the work cross-site.
* The Trust have recognised new requirements following recent publications from NHS Improvement; Patient Safety Incident Response Framework (PSIRF) and the Patient Safety Strategy.  These documents reflect considerable changes in previous approaches to governance and the Trust will need to consider new methodologies and processes in response to this.
* Providing smoke free hospital grounds imparts a clear message to all in society that smoking is harmful to health and provides an environment conducive with quitting. Quitting is not easy and a full package of supportive measures is planned to ensure that patients, staff and visitors are supported to quit or abstain whilst on hospital premises. Cleaner air and a reduction in litter caused by smoking will lead to a more pleasant environment for all people who work in and visit our hospitals.
* Considerable work has been carried out nationally to improve the identification and treatment of acute illness in order to prevent deterioration and cardiac arrest. This has drawn attention to the importance of timely escalation and the changes planned within this programme of work uses evidence based best practice to improve consistency in the recording and response to deterioration.
* There is detailed NICE guidance setting out the requirements to offer iron before surgery to patients with iron-deficiency anaemia. Improved compliance with this guidance would reduce blood transfusion rate for patients undergoing major blood loss surgeries, reducing the occurrence of patient safety risks associated with blood transfusion.
* The Trust have recognised new requirements following recent publications from NHS Improvement; Patient Safety Incident Response Framework (PSIRF) and the Patient Safety Strategy.  These documents reflect considerable changes in previous approaches to governance and the Trust will need to consider new methodologies and processes in response to this.
* Appropriate antibiotic prescribing for UTI in adults aged 16+
* Cirrhosis and fibrosis tests for alcohol dependent patients
* Staff flu vaccinations
* Some areas of discharge process can be improved to provide a better patient experience
* Programme to support patient safety and experience including
	+ improve learning from incidents, claims and complaints,
	+ support Just Culture
* Implement requirements of Smoke Free Hospital
* Treatment of community acquired pneumonia in line with BTS care bundle
* Rapid rule out protocol for ED patients with suspected acute myocardial infarction (excluding STEMI)
* Adherence to evidence based interventions clinical criteria
* Management of community acquired pneumonia has been a priority across the NHS for many years, particularly as part of the strategy for same day emergency care and also as part of winter planning. The care bundle, which is aligned with NICE guidance, sets out discreet steps that the Trust needs to follow with the aim to reduce mortality, length of stay and patient experience. Nationally, it is estimated that £765m spend per year and 29,000 deaths are associated with pneumonia.
* High sensitivity troponin tests are recommended as part of a rule out protocol for certain people attending as an emergency with chest pain. Improved compliance with the rapid rule out protocol will lead to improvements in the delivery of same day discharge, reducing length of stay and enhancing patient experience.
* The implementation of the evidence based interventions clinical criteria seeks to reduce the number of inappropriate interventions that patients receive by drawing on best practice guidance. There are 13 conditions where interventions should only be provided when certain clinical criteria are met. Compliance with the clinical criteria will reduce avoidable harm to patients and address unwarranted variation nationally. Robust implementation will ensure the most appropriate use of resources.

**Rationale**

* Recording of NEWS2 score, escalation time and response time for critical care admissions
* Screening and treatment of iron deficiency anaemia in patients listed for major elective blood loss surgery
* Programme to support patient safety and experience including
* improve learning from incidents, claims and complaints,
* support Just Culture

**Quality Priorities**

**Corporate Objectives**

**Improve Patient Safety**

**Deliver Excellent Clinical Outcomes**

**Improve Patient experience**

**Prevent ill health**

**Measures of Success**

* At least 60% of all antibiotic prescriptions for UTI in patients aged 16 and over, will meet NICE guidance for diagnosis and treatment.
* At least 35% of inpatients with a diagnosis of alcohol dependence will have a referral for a test to diagnose cirrhosis or advanced liver fibrosis.
* At least 90% of frontline staff with patient contact receive a flu vaccination.
* At least 70% of patients with confirmed community acquired pneumonia will:
* Have a chest x-ray within 4 hours of arrival in hospital;
* Have their pneumonia severity score calculated and documented in the medical notes
* Receive antibiotics within 4 hours of arrival in hospital;
* Receive antibiotics that are in accordance with the severity score and in line with NICE clinical guidance.
* At least 60% of patients attending ED with suspected acute myocardial infarction, who receive two high-sensitivity troponin tests, receive the second test within 3.5 hours of the first.
* At least 80% of patients undergoing any of the procedures defined in the national guidance (there are 13 category 2 procedures), meet the specific requirements set out in the Evidence Based Interventions clinical criteria specifications.
* At least 60% of unplanned critical care admissions from non-critical care wards, of patients aged 18 and over will:
* have a NEWS2 score recorded,
* have time of escalation recorded and
* have time of clinical response recorded.
* At least 60% of patients scheduled to undergo elective major blood loss surgery are screened, and appropriately treated for, iron deficiency anaemia in line with NICE guidance. They will have:
* A test to determine haemoglobin level
* A follow on test to determine whether any low Hb is caused by iron deficiency (serum ferritin)
* Where there is iron deficiency anaemia, the patient will receive oral or intravenous iron therapy in line with clinical guidance.
* Governance policies will have been adapted to reflect the new requirements of these documents and develop new processes accordingly. The Trust will develop a Patient Safety Incident Response Plan in accordance with Patient Safety Incident Response Framework (PSIRF)
* New governance structures which have been developed and incorporated into the new clinical service lines so as to ensure compliance with governance requirements.
* The Trust will monitor compliance with all new processes introduced via the newly established Clinical Quality Operations Board
* Increase the number of wards using the Reason to Reside categories at board rounds.
* Devise and pilot audit criteria for essential discharge communication to patients, families and care providers
* Measure and improve the time from decision to discharge until time the patients leave the wards
* Reduction in issues related to discharge medication.
* New governance structures will have been developed and incorporated into the new clinical service lines so as to ensure maximum learning from patient experience information.
* Existing policies will have been adapted cross-site to reflect the new requirements of national documents and develop new processes accordingly.
* After Action Review will have been implemented and used to support learning from incidents which impact on patient experience.
* The hospital sites are clearly signposted as being smoke free sites.
* People who are found to be smoking onsite are actively asked not to smoke onsite with information on how to quit being offered to them.
* Referrals to stop smoking services for inpatients increase by 100%.
* Nicotine replacement prescriptions increase by 50%.
* Staff will not be seen smoking either onsite, or whilst wearing uniform or lanyard even whilst off-site.

Trust Quality Committee

Trust Quality Committee

Trust Quality Committee

Trust Quality Committee

**Monitoring**

**Committee**

## 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 their peers.

During 2019/20, Bedford Hospital NHS Trust participated in all national clinical audits relevant to the health services that the trust provides. In summary, Bedford Hospital NHS Trust participated in 100% (49/49) of NHS England Quality Accounts national audits. Additionally the trust submitted data required for the JAG (Joint Advisory Group on GI Endoscopy) Accreditation Programme for Endoscopy.

Note: 5/49 of these audits comprised multiple work-streams

The national clinical audits in which Bedford Hospital NHS Trust was eligible to participate in, and for which data collection was completed during 2019/20:

|  |  |
| --- | --- |
| Bedford Hospital NHS Trust participation in NHS England Quality Accounts national clinical audits | Participation Status |
| Assessing Cognitive Impairment in Older People (Care in Emergency Departments) RCEM Audit (Royal College of Emergency Medicine) | Completed |
| BAUS (British Association of Urology Surgeons) Urology Audit: Female Stress Urinary Incontinence Audit | Continuous |
| BAUS Urology Audit: Nephrectomy Audit | Continuous |
| BAUS Urology Audit: Percutaneous Nephrolithotomy | Continuous |
| Care of Children (Care in Emergency Departments) RCEM Audit (Royal College of Emergency Medicine) | Completed |
| Case Mix Programme (CMP) | Continuous |
| Child Health Clinical Outcome Review Programme - NCEPOD | Continuous |
| Elective Surgery (National PROMS Programme) | Continuous |
| Endocrine and Thyroid National Audit |  Continuous |
| Falls and Fragility Fractures Audit Programme (RCP):Fracture Liaison Database:Inpatient FallsNational Hip Fracture Database | Continuous Continuous Continuous |
| Inflammatory Bowel Disease Programme (IBD Registry) | Continuous |
| JAG Endoscopy audits (38 topics) | Continuous |
| Learning Disabilities Mortality Review Programme (LeDeR) | Continuous |
| Major Trauma Audit (Trauma Audit & Research Network) | Continuous |
| Mandatory Surveillance of Bloodstream infections and Clostridium Difficile Infection (Public Heath England) | Continuous |
| Maternal, Newborn & Infant Clinical Outcome Review Programme (MBBRACE):Maternal Morbidity Confidential EnquiriesMaternal Mortality Surveillance and Mortality Confidential EnquiriesPerinatal Mortality and Morbidity SurveillancePerinatal Mortality Surveillance |  ContinuousContinuousContinuousContinuous |
| Medical and Surgical Clinical Outcome Review Programme: NCEPOD | Continuous |
| Mental Health – Care in Emergency Departments RCEM Audit (Royal College of Emergency Medicine) |   Completed |
| Myocardial Ischaemia National Audit Project (MINAP) | Continuous |
| National Asthma and COPD Audit Programme:Adult AsthmaChronic Obstructive Pulmonary Disease (COPD)Pulmonary Rehab | ContinuousContinuousCompleted |
| National Audit of Breast Cancer in Older Patients | Continuous |
| National Audit of Cardiac Rehabilitation (University of York) | Continuous |
| National Audit of Care at End of Life (NACEL) | Continuous |
| National Audit of Dementia Audit (RCPsych) Care in general hospitals | Completed |
| National Audit of Seizure Management in Hospitals (NASH3) | Completed |
| National Bowel Cancer Audit (NBOCA) | Continuous |
| National Audit of Seizures and Epilepsies in Children and Young People (RCPCH) | Continuous |
| National Cardiac Arrest Audit (NCAP) | Continuous |
| National Cardiac Audit Programme (NCAP):National Audit of Cardiac Rhythm ManagementNational Audit of Percutaneous Coronary Interventions – PCI (NICOR)National Heart Failure Audit | ContinuousContinuousContinuous |
| National Diabetes Audits – Adults:National Diabetes Audit (NADIA)National Diabetes - Foot Care Audit (NADIA) National Diabetes - Inpatient Adult (NADIA)National Diabetes - Insulin Pump Audit (NADIA)National Diabetes Audit - Pregnancy in Diabetes | ContinuousContinuousCompletedCompletedContinuous |
| National Early Inflammatory Arthritis (NEIAA) | Continuous |
| National Emergency Laparotomy Audit (NELA) | Continuous |
| National Heart Failure Audit (NICOR) | Continuous |
| National Joint Registry (NJR) | Continuous |
| National Lung Cancer Audit (NLCA) | Continuous |
| National Maternity and Perinatal Audit (NMPA) | Continuous |
| National Neonatal Audit Programme (NNAP) | Continuous |
| National Oesophago-Gastric Cancer Audit (NAOGC) | Continuous |
| National Paediatric Diabetes Audit (RCPCH) | Continuous |
| National Prostate Cancer Audit (Royal College of Surgeons) | Continuous |
| National Smoking Cessation Audit (BTS) | Completed |
| National Vascular Registry (Royal College of Surgeons) | Continuous |
| Perioperative Quality Improvement Programme (PQIP) Royal College of Anaesthetists | Continuous |
| Reducing the Impact of Serious Infections (Antimicrobial Resistance and Sepsis) Public Health England | Continuous |
| Sentinel Stroke National Audit Programme (SSNAP) | Continuous |
| Serious Hazards of Transfusion: UK National Haemovigilance Scheme | Continuous |
| Seven Day Services (NHS England) | Continuous |
| Society for Acute Medicine’s Benchmarking Audit (SAMBA) | Continuous |
| Surgical Site Infection Surveillance Service (Public Health England) | Continuous |
| UK Parkinson’s Audit | Continuous |

Published reports from national audits were shared with the relevant clinical teams and improvements undertaken to address any findings or recommendations.

#### National clinical audit reports

The majority of national clinical audits require continuous data collection and national reports are then generated, frequently 1 to 2 years after the data period. This provides an inaccurate sense of current status as internal understanding of audit outcomes may have been implemented and improvements initiated before the audit findings are published. National audits do notify trusts prior to any published report where there are significant outliers.

|  |  |
| --- | --- |
| National Audit | Improvement plans |
| Intensive Care National Audit and Research Centre (ICNARC): Case Mix Programme (2018/19) | Results reviewed and actioned at Critical Care team meetings |
| Learning Disabilities Mortality Review Annual Report 2018 | Discussed at the Bedford Hospital Learning from Deaths Board in June 2019Upward report to July 2019 Quality Board and then onwards to Trust BoardLetter received from NHS England May 2019 sent to CEO and Director of Nursing for them to share with medics in regards to ensuring that when completing death certificates that cause of death is not identified as Down’s Syndrome or Learning Disability – this was also discussed at the meeting |
| National Asthma and Chronic Obstructive Pulmonary Disease Audit (NACAP): Chronic Obstructive Pulmonary Disease Clinical Audit Report 2017/18 | Discussed at departmental meeting June 2019Online access to patient results for spirometry implementedDischarge bundle which is initiated on admission has prescription for oxygen prescribingPresentation on oxygen attended by all staff annually. This includes training on smoking status screeningSmoking status screening added on to discharge bundles to complete on admission and also added on as a task on ExtraMed |
| National Asthma and Chronic Obstructive Pulmonary Disease Audit (NACAP): Chronic Obstructive Pulmonary Disease Clinical Audit Report 2017/18 | Discussed at departmental meeting June 2019Online access to patient results for spirometry implementedDischarge bundle which is initiated on admission has prescription for oxygen prescribingPresentation on oxygen attended by all staff annually. This includes training on smoking status screeningSmoking status screening added on to discharge bundles to complete on admission and also added on as a task on ExtraMed |
| National Audit of Care at End of Life (NACEL) | Specific Bedford Hospital report discussed at March 2019 Integrated Medicine audit meetingFindings discussed at EoLC Steering Group and August 2019 QCRC |
| National Audit of Dementia – Care in General Hospitals 2018-19 - Round 4 Audit | Discussed at Quality Board Findings of report shared at Dementia Focus Group  |
| National Bowel Cancer Audit (Annual Report 2019) | Findings shared with all MDT membersDiscussed at Cancer Services Peer Review Operational meeting |
| National Cardiac Audit Programme: 2019 (NCAP) Annual Report : Improving Cardiovascular Outcomes: Timely Specialist, Evidence-Based Care | Heart Failure:Heart Failure Spotlight audit (part of the annual report) discussed at a Thursday morning Heart Failure MDTAction in place includes the appointment of more Heart Failure Nurses Trust achieves Heart Failure Best Practice Tariff (BPT) |
| National Emergency Laparotomy Audit 2019 | Discussed at Anaesthetics audit meetingsLocal audits undertakenEnsure NELA priority category is accurately documented and updated as necessary from information given by the senior surgical team member |
| National Oesophago-Gastric Cancer Audit it (NOGCA) | MDT team undertake review of high grade dysplasia (HGD) cases to ensure the diagnosis process is robust, that the diagnosis of HGD is confirmed by a second pathologist and that these patients are discussed at the specialist MDT teamPathway work underway to improve waiting times and improve the progression of patients from referral through to diagnosis and treatment. STT and early request of PET/EUS planned once waiting times for first OPA/OGD have reducedReview undertaken of patients who do not complete non-curative chemotherapy to understand the reasons why |
| National Neonatal Audit Programme (NNAP) | Discussed at Paediatric audit meetingContinual and regular surveillance of administration of antenatal magnesium sulphate to appropriate patients undertaken with obstetric colleaguesStaff training continues and review undertaken of all cases where temperature on admission is out of range in babies born at less than 32 weeks. All babies are now transferred on a trans-warmer with hats on as soon as possible after delivery. Ongoing encouragement to ensure delivery rooms are baby friendly and warmFollow up of children at 2 years of age is improving and action plan developed to assist with streamlining the process of recording the results |
| National Prostate Cancer Audit (NPCA) Annual Report 2019 | Findings shared with all MDT membersDiscussed at Cancer Services Peer Review Operational meeting |
| National Smoking Cessation Audit: Clinical & Organisational reports | Discussed at Respiratory Team meetingEducation delivered to all staff to raise awareness on improving the documentation regarding smoking cessation in the notesOngoing discussion regarding adding a field on recently introduced Symphony software to capture smoking statusTo liaise with the Smoking Cessation service to improve the documentation on the referrals to the serviceAll staff to be given training on screening of patients who are non-cigarette smoking |
| Trauma Audit and Research Network (TARN) 2019 | Regular meetings to discuss findings from quarterly reports and review cases/practice |
| National Vascular Registry (Royal College of Surgeons of England) Annual Report 2019) | Reports are discussed and actioned at vascular meetings |

As referenced earlier, 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 45 local clinical audits, re-audits and quality improvement topics, were reviewed by Bedford Hospital NHS Trust in 2019/20 and the Trust intends to take the following actions to improve the quality of healthcare provided. The audit results and recommendations were presented at the appropriate audit and departmental meetings.

#### Local clinical audits and associated improvement plans:

| **Local clinical audit** | **Month presented** | **Outcome** |
| --- | --- | --- |
| Integrated Medicine |
| Management of Acute Asthma Exacerbation – QI project | May 2019 | Discussed at Integrated Medicine audit meetingE-mail referral service being set up for the respiratory nursing serviceA peak flow meter will be available on all wardsFurther training on care bundles being delivered to all frontline staffOngoing QI topic |
| Re-audit of Acute Kidney Injury Management In Acute Admissions | May 2019 | Discussed at Integrated Medicine audit meetingEducation to be delivered to clinical staff (junior doctors and nursing staff regarding the need to do a urine dip on patient admission or on identification of AKI and to ensure the results are documented in the correct section of the emergency booklet, medical and nursing notesClinical Nurse Educator to include AKI results documentation awareness in CSW training CCC (Critical Care Complex) matron to ask Critical Care Outreach Team to reinforce message regarding AKI stickers and urine dipsEducation to be delivered to AAU nursing staff regarding the use of AKI stickersRe-audit in 12 months |
| Re-audit Ambulatory Emergency Care Unit (AECU) Service | May 2019 | Discussed at Integrated Medicine audit meetingIncrease staff awareness of specialty clinicsDiscussion planned to improve effective utilisation of AECU Doppler slotsUndertake negotiation for CT slots to facilitate quick diagnosis/exclusion of PELook into strategies to extend the provision of the AECU services |
| Abdominal X-ray Requests From A&E(Audit & Re-audit) | May 2019September 2019 | Discussed at Radiology audit meetingTraining session to be undertaken with A&E consultants and juniors regarding referring patients for abdominal x-rays according to RCR (Royal College of Radiologists) guidelinesPoster to be drawn up to with referral guidance and displayed in the departmentRe-auditRe-audit discussed at Radiology audit meetingLunchtime teaching given to A&E clinical staffInformation poster now displayed in A&E and AAURe-audit planned for September 2020  |
| Radiation Awareness(Audit & Re-audit) | May 2019September 2019 | Discussed at the Radiology audit meetingTeaching session to be given by Radiology department to junior doctorsRadiation awareness information included in induction to alert all junior medical staff regarding UK regulationsPoster on UK regulations to be emailed to all junior staff and posters displayedRe-audit discussed at Radiology audit meetingJunior doctors receive radiation awareness teaching during InductionInformation poster devised and relevant radiation awareness information cascaded to staff verbally and via emailRe-audit planned for September 2020  |
| Relationship of Sedation Given During Endoscopy and Outcome of Gastroscopy and Colonoscopy | July 2019 | Discussed at Endoscopy Users Group meetingUpdate Unisoft software for fewer choices for recording failure reasons to streamline systemThe Endoscopy Assessment team will continue to emphasise to patients the importance of following the instructions for bowel preparation to assist with ensuring the procedure is successful |
| Comparison Between Venous Blood Gas Analysis Values at Point of Care Testing (POCT) in the Emergency Department and Laboratory Values | September 2019 | Discussed at Integrated Medicine Audit meetingAs the differences between the two values were found to show clinical significance all ED doctors were made aware of the data4 monthly regular ED teaching takes place to registrars and foundation/SHO doctors to ensure each new cohort of doctors is aware of the differences Results presented in a poster presentation at the Royal College of Emergency Medicine National Scientific Conference October 2019Plan to write a scientific paperRe-audit following the gas analyser machine being set up to incorporate testing for urea and creatinine at the end of 2019 |
| Re-audit of Triage in the Emergency Department | September 2019 | Discussed at Integrated Medicine Audit meetingDiscussed at ED Registrar teachingRe-audits undertaken quarterlyFurther training delivered to staff on a continuous basis to reinforce the triage protocol e.g. “shop floor” teaching to all grades including juniors, middle grades and nursing staffTeaching sessions, handover meetings and inductions utilised in order to teach triage categories and appropriate timesBetter communication in ED is in place between the “shop floor” team and the triaging team whereby teams are bleeped when there are more than 5 patients needing to be triagedRe-audit following implementation of Symphony IT system in EDFollowing re-audit plan to present at RCEM (Royal College of Emergency Medicine) National Scientific conference in 2020 |
| Documentation in the Emergency Department (ED) | September 2019 | Discussed at the Integrated Medicine audit meetingImportance of documentation in ED meeting RCEM and GMC guidance regularly disseminated in ED teaching on a quarterly basis to ensure each new cohort of doctors is aware of the expected standards. ED arranges both Registrar and Foundation/SHO teachingRe-audit to take place following implementation of the Symphony system in ED  |
| Ultrasound Guided Fine Needle Aspiration of Thyroid Nodules | September 2019 | Discussed at the Radiology Audit meetingFindings also discussed with pathologists and cytopathology laboratory technicians to try to ascertain reasons for inadequate sampling   |
| EBUS (Endobronchial Ultrasound-guided) Annual Data Review  | October2019 | Discussed at Respiratory Consultants’ Team meetingTotal number of cases met as per business planIncreased number of referrals show that the demand for the procedure is increasing, therefore request for a business plan to be drawn up to buy a second EBUS scope to increase capacity and also help with meeting the 28 days cancer target |
| Planned Care |
| Delayed Discharges from Critical Care Complex | May 2019 | Discussed at CCC M&M (Mortality & Morbidity) meeting |
| Perioperative Management of Patients on Anticoagulants | May 2019 | Discussed at the General Surgery audit meetingDiscussed at Anaesthetics departmental meeting Pre-operative Assessment clinic to be advised regarding instructions on stopping NOACs (Novel Oral Anticoagulants)Surgeons made aware of the Bridging Clinic run by the Haematologists for advice regarding correct bridging therapy for patients on warfarinRe-audit in 6 months |
| Variations in Written Consent for Laparoscopic Cholecystectomy | May 2019 | Discussed at the General Surgery audit meetingTo investigate the use of a sticker for complications either to be put in the consent forms or used as guidance  |
| Unplanned Hospital Admissions After Day Surgery: QI topic | May 2019 | Discussed at the General Surgery audit meetingReview admitted patients the following day to identify relevance of admissionFor these admissions:Undertake closer monitoring of the notes to obtain “real time” dataReview of pre-operative checklistReview of intra-operative pain and PONV (postoperative nausea and vomiting) |
| Improving the Administration of Anti-Embolic Stockings (AES) for Venous Thromboembolism (VTE) Prophylaxis for Surgical Patients  | May 2019 | Discussed at the General Surgery audit meetingMeeting with ward managers and ward clerks to ensure that there is visible access to patient leaflets and there are standard procedures in place to confirm distribution with each admissionMeeting to be arranged with senior nurses to discuss/highlight discrepancies between administration tick boxed and reality of patients wearing stockingsOngoing training workshops for nursing staff on surgical wards explaining the importance of VTE prevention and measurement/accurate administration of AESEmails/posters for doctors to encourage discussion/prescription of AES with patientsSurgical post-take consultant proforma with prompt to review and document VTE assessment introduced in August 2019 ahead of the new junior doctor rotationRe-audit March 2020 |
| Enhanced Recovery in Colorectal Surgery | May 2019 | Discussed at General Surgery audit meetingAn enhanced recovery form to be followed and signed by the nursing team has been introducedTeaching sessions on enhanced recovery delivered to nursing staff |
| Plastic Surgery Pre Operational Stage Quality Improvement  | May 2019 | Discussed at the Plastic Surgery audit meetingPlastic Surgery and Hand Trauma Service Leaflet devised and in use  |
| Post-operative Nausea and Vomiting in Day Case Patients | May 2019 | Discussed at the Anaesthetics meetingCurrent practice is in line with national guidance so no re-audit plannedAll clinicians reminded of maintaining good practice |
| On The Day Cancellation of Elective Orthopaedic Operations | May 2019 | Discussed at the T&O meetingSurgeons reminded to ensure TCI form is fully completed for all elective patientsDiscussions underway regarding the sending of reminder texts to patients regarding their operation datesOrthopaedic SHOs request lists of TCI elective patients the week prior to surgery and check blood results in order to highlight any potential problemsAt pre-op assessment all patients are given information regarding the dangers of presenting for surgery if unwell and the trust’s re-booking policy if this occurs |
| Delays in Post-operative X-rays in Elective THR & TKR | May 2019 | Discussed at T&O meetingPolicy training organised for radiographersLook into auditing in other surgical areas to provide evidence for business plan for additional radiographer |
| The Role of Pre-Clinic MRI in the Implementation of the 28 Day Prostate Cancer Diagnostic Pathway – Cycle 2 | July 2019Regional meeting  | Discussed at the East of England Cancer Alliance meeting Full implementation of pre-clinic MRI for all patients enrolled in the pathway3 monthly review of the pathway in place |
| Follow Up Protocol for TCC (Transitional Cell Carcinoma) of Bladder(Audit & Re-audit) | June 2019September 2019 | Discussed at the Urology MDT (Multi-disciplinary team) meetingPoster devised on the follow up schedule for patients with TCC of bladder based on NICE, EAU, Anglia Cancer Network and Urology NCG guidelines and displayed in the relevant departmentsOngoing discussion to standardise the follow up process in Bedford hospital to reduce unnecessary follow upRe-audit annuallyDiscussed at Urology Departmental meetingAll patients diagnosed with high risk TCC bladder to have a routine 1 year follow up CTU (computerised tomography urogram) undertaken as per implemented upper tract imaging protocol |
| Percutaneous Cholecystostomy Audit | September 2019 | Discussed at the General Surgery audit meetingTo increase IR (interventional radiology) to cover leave and weekendsBedford Hospital Percutaneous Cholecystostomy Algorithm/Pathway to be devised |
| Post-operative Anaemia in Vascular Patients | September 2019 | Discussed at the General Surgery audit meetingTraining session organised for junior doctors to assist with understanding the importance of post-operative measurement of Hb and iron levels and on the interpretation and management of iron deficiency anaemia, particularly in high risk patientsNew hospital policy on the management of post-operative anaemia in development  |
| Adequacy of X-ray Imaging for Hand Injuries | September 2019 | Discussed at Plastic Surgery Team meetingLocal policy implemented regarding imaging in suspected hand fracture or dislocation – 3-view radiological examination should be a standard  |
| Prostate Cancer – Re-audit Use of Bone Scans in Patients with Gleason 3+4 and PSA <10  | September 2019 | Discussed at Urology Departmental meetingImplementing the omission of bone scan in intermediate risk prostate cancer, predominantly Gleason 3 and PSA <10, in the absence of symptoms |
| Evaluation of Current Diverticular Abscess Management at Bedford Hospital | September 2019 | Discussed at departmental Clinical Governance meetingClinicians made aware of importance of appropriate antibiotic regimes for Diverticulitis and consistency of prescribing to be improved by following NICE guidelines or the hospital policy  |
| Negative Appendicectomy Rate at Bedford Hospital | November 2019 | Discussed at the General Surgery audit meetingPatients to undergo extensive evaluation, especially young females, before planning for surgeryTo ensure that there is easy availability of imaging for patients with suspected appendicitis |
| Re-Audit Abscess Pathway  | November 2019 | Discussed at Anaesthetic audit meetingDiscussions with the Tavistock ward manager regarding podding of the patient files to the ward. When transferring physically, patient files to be kept in Theatre 4 box Intranet updated to include abscess pathway flowchart and patient leaflet |
| Patient Feedback in Plastic Surgery | November 2019 | Discussed at Plastic Surgery departmental meetingStaff encouraged to avoid delays to surgery where possible and reminded of the importance of patient/doctor relationship and good communicationTo deliver teaching sessions to all A&E and referring doctors regarding following guidelines about case prioritisation and when it is appropriate to overbookRe-audit 2021 |
| TCI Forms Audit | November 2019 | Discussed at Plastic Surgery departmental meetingA six month continuous monitoring of the TCI form has been set up to ensure all sections of the form are completed and are legible  |
| Re-Audit Prolonged Length of Stay Post Total Hip Replacement (THR) | November 2019 | Discussed at T&O audit meetingImplementation of criteria led discharge (CLD)Plan to enhance the recovery protocol for THR patients |
| Review of the Percentage of Patients Who have Had Consultant review Within 14 Hours of Admission | November 2019 | Discussed at the General Surgery audit meetingTo introduce proformas for common urological presentations e.g. renal colic and epididymo-orchitis and then undertake a re-audit of patients being reviewed in the 14 hour window, with the above excluded as per guidelinesConsultants educated of these requirements at departmental meetingsRe-audit January 2021  |
| Post-operative Complications of Suprapubic Catheter Insertions (SPC) (LC cases) | November 2019 | Discussed at the General Surgery audit meetingTeaching session delivered on SPCs to all junior doctors |
| Women and Children |
| Pain Scoring and Inpatient Satisfaction With Pain Control – O&G Re-audit 2019 | May 2019 | Discussed at the O&G audit meetingAudits carried out across all specialties on a 6 month rolling basisPrescribing practice in obstetrics to be monitored by the matronWork being undertaken to continue improving the timings of drug rounds in maternity and monitor any dose omissionsOngoing regular education in pain control management for nursing staffPatient information leaflets on available methods of pain relief being devised |
| Children with Coeliac Disease April 2018 - March 2019 (Joint collaboration with Nutrition and Dietetics) | May 2019 | Discussed at the Paediatric audit meetingPaediatric medical teams will contact the specialist paediatric dietitian for every newly diagnosed patient via telephone or email in addition to the current practice of the sending of a letterLook into developing basic first line dietary advice to be sent to patients if they are not able to make appointments within 2 weeksHighlight to patients that there is limited availability of clinic slots to try and minimise cancellation and non-attendance |
| Management of IV Fluids for Children and Young People Under 16 Years | November 2019 | Discussed at Paediatric audit meetingPhysicians made aware of need for complete identification, clear signature and bleep number on all prescription chartsInput and output charts must document weights accuratelyDiscussions must take place before a decision is made regarding uniformity of fluid useRe-audit |
| Integrated Medicine & Planned Care |
| Chest Drain Insertion Audit | May 2019 | Discussed at Integrated Medicine and General Surgery audit meetingsChest drain (bottle) training delivered to physicians and surgeonsTeaching sessions delivered every 4 monthsSafety alert on the use of the Safer Surgery checklist to be sent to all clinical staffChest drain chart is being updated to included swinging and bubblingRevised chest drain chart available on the trust intranet and information sent to all wardsRe-audit 2020/21 |
| Percutaneous Cholecystostomy Audit | September 2019 | Discussed at the Radiology and General Surgery audit meetingsIR availability will be increased to cover leave and weekendsBedford Hospital Percutaneous Cholecystostomy Algorithm/Pathway to be drawn upRe-audit November 2020 |
| Treatment Escalation Plan (TEP) With Resuscitation Decision (Formerly DNACPR) | January 2020 | Discussed at the Integrated Medicine and General Surgery audit meetingsTEP form adapted to:* include box if communication is delegated to another member of staff
* include box asking if patient has Learning Disability

Merged Resuscitation Committee to review and discuss ReSPECT ( Recommended Summary Plan for Emergency Care and Treatment) document at May 2020 meeting  |

### Local Patient experience surveys and associated actions

|  |
| --- |
| **Patient experience** |
| Integrated Medicine |
| Acute Respiratory Assessment Service (ARAS) Patient Survey | Discussed at Respiratory Team meetingEstates relocated the signage for the ARAS clinicSeating area in the clinic has been improvedTo look into ways of improving the communication with patients regarding proceduresOngoing annual patient survey |
| Early Supported Discharge Scheme (ESDS) Patient Survey | Discussed at Respiratory Team meetingImprove patients’ knowledge of their condition by encouraging enrolment in Pulmonary RehabilitationPatients provided with a Health Plan and British Lung Foundation (BLF) informationOngoing annual patient survey |
| Home Oxygen Service (HOS) | Discussed at Respiratory Team meetingPatients are provided with Respiratory Nurse Specialist business cards at each contact with the nursing team to ensure that they always have their contact details to handOngoing annual patient survey |
| Plastic Surgery |
| Patient Feedback in Plastic Surgery | Discussed at Plastic Surgery departmental meetingStaff encouraged to avoid delays where possible and reminded of the importance of patient/doctor relationship and good communicationDelivering teaching sessions to all A&E and referring doctors regarding following guidelines about case prioritisation and when it is appropriate to overbookRe-audit 2021 |

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 2019/20, 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

|  |  |
| --- | --- |
| **NCEPOD** | **Percentage participation** |
| Acute Bowel Obstruction | 100% |
| Long Term Ventilation | No patients were identified |
| Dysphagia in Parkinson’s Disease | Study in set up |

### Participation in clinical research

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 number of patients receiving health services provided or sub-contracted by the Trust in 2019/20, that were recruited during that period, to participate in research, approved by a research ethics committee was 490. This includes both portfolio and non-portfolio studies. In addition there are 520 patients in the follow up process.

The Trust was involved in conducting 28 clinical research studies in 2019/20 including the following areas: oncology; ophthalmology; cardiology; haematology; dermatology; surgery; midwifery; paediatrics; gastroenterology; anaesthetics and respiratory medicine.

More than 42 clinical staff participated in research approved by a research ethics committee at the Trust during 2019/20. These staff participated in research covering 11 specialties.

In the last three years, 118 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 2019/20 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 2019/20 five CQUINs applied to the Trust (listed in table 7), all were mandated nationally.

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

* Medicines Optimisation
* TARN

|  |  |  |  |
| --- | --- | --- | --- |
| **Indicator identifier** | **CQUIN Name and description** | **Overall achievement of target (%) for 2019/20** | **Projected achievement of target (%) for 2019/20 at Q3** |
| CCG1a  | Antimicrobial Resistance – Lower Urinary Tract infections in Older People Achieving 90% of antibiotic prescriptions for lower UTI in older people meeting NICE guidance for lower UTI (NG109) and PHE Diagnosis of UTI guidance in terms of diagnosis and treatment. | TBC | 67% |
| CCG1b | Antimicrobial Resistance – Antibiotic Prophylaxis in colorectal surgery Achieving 90% of antibiotic surgical prophylaxis prescriptions for elective colorectal surgery being a single dose and prescribed in accordance to local antibiotic guidelines. | TBC | 93% |
| CCG2 | Staff Flu Vaccinations Achieving an 80% uptake of flu vaccinations by frontline clinical staff | TBC | 71% |
| CCG3a | Alcohol & Tobacco – Screening Achieving 80% of inpatients admitted to an inpatient ward for at least one night who are screened for both smoking and alcohol use. | TBC | 24% |
| CCG3b | Alcohol & Tobacco – Tobacco Brief Advice Achieving 90% of identified smokers given brief advice. |  TBC | 51% |
| CCG3c | Alcohol & Tobacco – Alcohol Brief Advice Achieving 90% of patients identified as drinking above low risk levels, given brief advice or offered a specialist referral. | TBC | 44% |
| CCG7 | Three high impact actions to prevent Hospital Falls Achieving 80% of older inpatients receiving key falls prevention actions | TBC | 19% |
| CCG11a | Same Day Emergency Care (SDEC) – Pulmonary Embolus Achieving 75% of patients with confirmed pulmonary embolus (PE) being managed in a same day setting where clinically appropriate. | TBC | 78% |
| CCG11b  | Same Day Emergency Care (SDEC) – Tachycardia with Atrial Fibrillation Achieving 75% of patients with confirmed atrial fibrillation (AF) being managed in a same day setting where clinically appropriate. | TBC | 89% |
| CCG11c | Same Day Emergency Care (SDEC) – Community Acquired Pneumonia Patients with confirmed Community Acquired Pneumonia (CAP) should be managed in a same day setting where clinically appropriate. | TBC |  67% |

Table 7: Bedford Hospital NHS Trust achievement against 2019/20 CQUINs

## 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 been inspected since September 2018, when it was rated as Requires Improvement. Since the inspection the Trust has been delivering a comprehensive improvement plan to underpin its response to the CQC recommendations but also to have learnt from the inspection and identified other areas for improving patients’ services and experience.

#### Inspection overview

The 2018 inspection ratings are highlighted in Figure 1 and show an increase in overall ratings of 80% good with three key patient-facing services improving considerably since the last inspection.



## Duty of candour

The Trust continues to comply with its statutory duty under the Duty of candour legislation 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.

### Learning and being open

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 serious incident (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.

#### Speak Up Safely

In response to the Gosport Independent Panel Report, the trusts has put in several ways that staff can speak up. This includes feedback to those who speak up, and give assurance to staff who do speak up do not suffer detriment.

Staff at Bedford Hospital have a number of routes they can follow, to speak up about a range of matters that are of concern to the individual.

Freedom to Speak Up Guardian is a confidential service where staff can report risks, wrong- doing or malpractice. The Guardian has direct access to the Chief Executive and reports to the Trust Board on issues and themes raised and solutions. The Guardian gives an undertaking to maintain confidentiality in any reporting that takes place.

At the end of 2019 we appointed Four Freedom to Speak up Champions to help the Guardians work. The Champions hold a variety of roles within the Trust, Human Resources, Portering, nursing and Consultancy. This diversity ensures that all Champions have a good understanding of the areas within the hospital and will be able to listen and understand concerns that are raised. They are in the process of being trained nationally.

2019 saw 10 more Peer2Peer listeners trained up bring a total of 22 listeners ready and able to listen to staff concerns either work related or personal. The listeners report through to the Freedom to Speak up Guardian. This was launched as part of the Trust’s commitment to the Social Partnership Forum’s Call to Action to tackle bullying in the NHS. It is also intended to act as a signposting service to other support services and solutions. This service supports but does not replace other ways in which the Trust supports it staff.

Other means of staff support are provided through the chaplaincy team, trade unions, occupational health and counselling services.

Feedback to those who speak up will be given to individuals through the Guardian role, trade union and professional organisation representatives, with individuals representing these roles, committed to ensuring that individuals do not suffer detriment as a result of any disclosure.

## Data quality

Bedford Hospital NHS Trust submitted required datasets during 2019/20 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:

* 99.75% for admitted patient care;
* 99.93% for outpatient care; and
* 99.27% for accident and emergency care.

That included the patient's valid General Practitioner registration code was:

* 99.75% for admitted patient care;
* 99.88% for outpatient care; and
* 98.21% for accident and emergency care.

### Data Security & Protection Toolkit (DSPT)

Bedford Hospital NHS Trust’s data security and protection assessment for 2019/20 submitted a response confirming that it did not currently meet all the relevant mandatory standards, a position of ‘Standards Not Fully Met’.

The action plan has not been formally approved by NHS Digital, as Bedford Hospital NHS Trust no longer exists from 1 April 2020 and has merged with Luton & Dunstable Hospital to form Bedfordshire Hospitals NHS Foundation Trust.

The newly formed Trust will combine the DSPT improvement plans from both former Trusts and expects to meet all the required standards during 2020/21.

#### Clinical coding accuracy

The Trusts clinical coding was assessed against the Secondary user assurance within the framework of the DSPT in October 2019 which is now based on the following attainment levels and concluded the coding is of very high standard and satisfies the requirements of the Data Security standards level 1 and that the this achievement is to be commended.

* Data Security Standard 1 – Data Quality – Standard Exceeded
* Data Security Standard 3 – Training – Standard Exceeded

Bedford Hospital NHS Trust will continue to improve its Data Quality by:

* Continuation of clinical involvement in coded data
* Ensure data Quality Audits are carried out across key datasets and processes

and any recommendations are acted upon.

* Active involvement in the Trusts implementation of its EDMRS project
* Continued review of Data exceptions and feedback through existing Data quality forums

## Learning from deaths

### Learning from Deaths – Quarterly Report 14/07/2020

#### 2019/20

The quarterly report on Learning from Deaths is usually published 3 months in arrears to allow time for case note review and to identify any learning. It should be noted that this does not replace the monthly reporting of mortality metrics (1 month in arrears), other mortality indicators (6 month data set) or the SHMI report (published monthly).

This report focuses on the year April 2019 – March 2020. It should be highlighted that data for Quarter 3 and Quarter 4 will be incomplete due to the need to prioritise clinical time on dealing with the Covid-19 pandemic. All serious incident deaths, elective deaths or where concerns have been identified were prioritised for review. Deaths were also screened by the Medical Examiner (ME).

Bedford Hospital’s position prior to merger was that all deaths are under scope for review; this was an internal standard which was stricter than national guidance which highlighted deaths which required review. As the Medical Examiner becomes fully implemented, all deaths will be screened by the ME with selected deaths only undergoing a second-stage structured judgement review. Post-merger we are in the process of moving both hospital sites to the Datix Cloud IQ system which will allow use of the electronic structured judgement review.

Avoidable deaths include:

* Those investigated under the SI Framework (as reported to board monthly) and assessed as avoidable (N.B. there will be a delay between date of death and determination of avoidability due to the time required to complete the investigation 60 working days).
* Those graded as NCEPOD ‘E’ on mortality review (less than satisfactory) with a preventability score of 3 (probable avoidable death).
* Deaths deemed avoidable following a coroner’s inquest.

|  |  |  |
| --- | --- | --- |
| Inpatient deaths | Total | Reviews completed |
| Quarter 1 | 209  | 98 (47%)  |
| Quarter 2 | 194 | 87 (45%)  |
| Quarter 3 | 225 | 61 (27%) |
| Quarter 4 | 234 | 30 (13%) |
| Overall 2019/20  | 862  | 276 (33%)  |

Q1 figures exclude one death in a patient who was transferred to another centre with necrotizing fasciitis. A further 3 deaths are subject to external review: one child death which is being reviewed through the CDOP; one maternal death and one neonatal death which are under investigation by the HSIB. All cases were reported through the SI process.

#### Outcomes of reviews

For the year ending 31/03/2010, 3 cases have been classed as possibly avoidable.

Three cases are still awaiting an inquest and will undergo mortality reviews once the inquest has concluded. A further 3 cases are under review post-inquest and 2 are still being investigated through the SI process.

Preventable deaths (>50% probability) – 0% of cases reviewed (n=0)

\*NB. Note data may change following completion of SI investigations and outcomes of inquests

#### Deaths in people in groups under special focus – 2019/20

|  |  |  |
| --- | --- | --- |
| Group | Total | > 50% likely preventable |
| People with learning disabilities\*Included in above figures | 4 reviewed (n=4)  | 0  |
| People with severe mental illnessIncluded in above figures | 0 reviewed (n=0) | 0 |
| Maternal deaths, child deaths, stillbirths | Not reported through LfD methodology |

One further death in a patient with learning difficulties (expected end of life) was a community death and not included in the above figures.

Two patients with learning disabilities contracted covid-19 and died in hospital during Q4. Mortality reviews for these patients are in progress.

#### Learning themes identified

|  |  |
| --- | --- |
| Contributing to preventable deaths  | The need for consultant-to-consultant discussion for sick patients  |
| Contributing to preventable deaths | Admission of patients with unsuspected surgical problems to medical wards |
| Not contributing to death | Failure to recognise patients requiring end of life care and over investigating/over treating them. |

Adapted from West Suffolk Hospital NHSFT (acknowledgements - H Jopling, N Jenkins)

#### Medical Examiner update

Three medical examiners are in post at Bedford. The first started working one day a week in January. In March 2020, two of the MEs returned to full time clinical work during the pandemic and the third took over duties working 5 mornings a week. All three are now working covering Monday to Friday. The MEs scrutinise all deaths and if concerns will liaise with the coroner and/ or proceed to a formal mortality review through the Learning from Deaths process.

A Lead ME for the merged organisation was appointed in March 2020 and will be working with the Senior Coroner for Bedfordshire and Luton to further establish the process.

## National indicators in care quality 2019/20

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.

|  |  |  |
| --- | --- | --- |
| 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 |

Table 10: Five domains of the NHS Outcomes Framework

### Our performance against 2019/20 quality indicators

Eight Quality Account indicators apply to Bedford Hospital NHS Trust in 2019/20:

* 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 hip replacement surgery and 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.

|  |  |  |  |
| --- | --- | --- | --- |
|  | 2017/18 | 2018/19 |  2019/20 |
| Bedford Hospital NHS Trust | 1.041Band 2 ‘as expected’ 26.3% palliative care | 1.057Band 2 ‘as expected’ 27.9% palliative care | 1.08Band 2 ‘as expected’27% palliative care |
| England average | 1.00 | 1.00 | 1.0 |
| Best performing Trust | 0.727Band 3‘lower than expected’ | 0.691Band 3‘lower than expected’ | 0.69Band 3‘lower than expected’ |
| Worst performing Trust | 1.247Band 1‘higher than expected’ | 1.268Band 1‘higher than expected’ | 1.20Band 1‘higher than expected’ |

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

Notes:

* 2017/18 data = October 2016 to September 2017 (published March 2018)
* 2018/19 data = October 2017 to September 2018 (published Feb 2019)
* 2019/20 data = April 2019 to March 2020 (published August 2020)

**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 monthly.

**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 Learning from Deaths Board
* Commissioned reviews of mortality outliers. Primary care input has been requested to review out of hospital deaths; this action is outstanding.
* 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 initially covered four common elective surgical procedures: groin hernia operations, hip replacements, knee replacements and varicose vein operations. PROMS for varicose vein surgery and groin hernia are not mandatory and no longer undertaken [for varicose vein surgery modern treatments mean that a general anaesthetic open operation is rarely needed].

PROMs relate to NHS Outcomes Framework domain three: helping people to recover from episodes of ill health or following injury.

#### 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.

|  |  |  |  |
| --- | --- | --- | --- |
|  | 2017/18 | 2018/2019 | 2019/20 |
| Bedford Hospital NHS Trust | 21.75 | 22.5 | 22.16 |
| England average | 22.2 | 22.3 | 22.45 |
| Best performing Trust | 25.0 | 25.3 | 25.78 |
| Worst performing Trust | 18.0 | 18.64 | 18.25 |

Table 14: Patient Reported Outcome Measures (PROMs) for hip replacement surgery

Source: Health and Social Care Information Centre [(http://www.hscic.gov.uk/proms)](http://www.hscic.gov.uk/proms%29)

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

* 2017/18 - provisional data due to be published in May 2018 for period April 2017 to December 2017
* 2018/19 – for period April 2019 to September 2019
* 2019/20 data = provisional data published August 2020

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.

#### 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.

|  |  |  |  |
| --- | --- | --- | --- |
|  | 2017/18 | 2018/19 | 2019/20 |
| Bedford Hospital NHS Trust | 18.89 | 16.5 | 18.03 |
| England average | 17.1 | 17.2 | 17.3 |
| Best performing Trust | 20.39 | 19.9 | 20.62 |
| Worst performing Trust | 12.89 | 13.54 | 12.29 |

Table 15: Patient Reported Outcome Measures (PROMs) for knee replacement surgery

Source: Health and Social Care Information Centre [(http://www.hscic.gov.uk/proms)](http://www.hscic.gov.uk/proms%29)

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

* 2017/18 - provisional data due to be published in May 2018 for period April 2017 to December 2017
* 2018/19 – for period April 2018 to December 2018
* 2019/20 data = provisional data published August 2020

### Emergency readmissions to the hospital within 30 days of discharge

#### Domain 3b

Emergency readmissions to the hospital within 30 days of discharge relates to NHS Outcomes Framework domain three: helping people to recover from episodes of ill health or following injury.

|  |  |  |  |
| --- | --- | --- | --- |
|  | 2017/18 | 2018/19 | 2019/20 |
| 0 to 15 years of age | 7.98% | 7.83% | Unpublished  |
| 16 years and over | 7.68% | 8.10% | Unpublished  |

Table 16: Emergency readmissions to the hospital within 30 days of discharge

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

Notes:

There is an on-going review by NHS Digital of emergency readmissions indicators across the frameworks, many of which have not been published since 2014. Phase one of this review involves the publication of two indicators in early 2019: CCG Outcomes Indicator Set indicator 3.2 and NHS Outcomes Framework indicator 3b – Emergency readmissions within 30 days of discharge from hospital.

* 2017/18 - data provided via CHKS source – admitted patient care dataset
* 2018/19 - data provided via CHKS source – admitted patient care dataset
* 2019/20 – data unpublished

**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 an implement a reduction in readmission for under 16 years of age
* The Trust will work with its strategic partners and continue its improvement work stream 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.

|  |  |  |  |
| --- | --- | --- | --- |
|  | 2017/18 | 2018/19 | 2019/20 |
| Bedford Hospital NHS Trust | 64.2 % | 62.1 | Unpublished  |
| National average | 68.6 % | 67.2 | Unpublished  |
| Best performing Trust | 85.0 % | 85 | Unpublished  |
| Worst performing Trust | 60.5 % | 58.9 | Unpublished  |

Table 17: Responsiveness to the personal needs of patients

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

Notes:

The Trust awaits publication of data for 2019/20 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.

|  |  |  |  |
| --- | --- | --- | --- |
|  | 2017/18 | 2018/19 | 2019/20 |
| Bedford Hospital NHS Trust | 67% | 71% | 67% |
| England average | 71% | 71% | 71% |
| Best performing Trust | 86% | 87% | 87% |
| Worst performing Trust | 47% | 40% | 40% |

Table 18: Percentage of staff who would recommend the Trust to friends or family needing careSource: 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.

|  |  |  |  |
| --- | --- | --- | --- |
|  | 2017/18 | 2018/19 | 2019/20 |
| Bedford Hospital NHS Trust | 98.02% | 97.65% | 97.34% (Q1-Q3) |
| England average | 95.26% | 95.7% | 95.6% |
| Best performing Trust | 100% | 100%  | 100% |
| Worst performing Trust | 77.78% | 74%  | 71% |

Table 19: Percentage of admitted patients who were risk assessed for venous thromboembolism

Source: NHS England [(http://www.england.nhs.uk/statistics/statistical-work-areas/vte/)](http://www.england.nhs.uk/statistics/statistical-work-areas/vte/%29)

Notes:

* 2019/20 data = published data for 2019/20 is for the first three quarters.

**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 add chart 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 were 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 of 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).

The Trust was set a ceiling trajectory of nine hospital apportioned cases of laboratory confirmed (GDH positive and toxin positive) cases of clostridium difficile. To date the Trust has been apportioned nine cases, of which three are awaiting appeal following root-cause analysis, two remain under review process with the clinical area. In all cases there is no evidence to suggest cross infection between patients has occurred, as the ribotyping is different for each specimen.

The Trust has continued to implement the following actions:

* Prompt identification of patients with potential symptoms or at risk
* Prompt escalation of patients with diarrhoea to the infection prevention and control team and site management team
* Prompt isolation of patient’s as agreed with the CCG
* Timely specimen collection from the patient
* Utilising an infection prevention and control admission risk assessment form.
* Continue to conduct root cause analysis for each case and share the learning
* Ongoing antimicrobial stewardship throughout the Trust

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 and improve compliance with levels 1 and 2 on IPC training to achieve a target of 90% compliance

Working with the CCG infection prevention lead to review the format of the documentation in the review process in line with the changing target criteria which had been set for 19/20.

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

#### Domain 5

|  |  |  |  |
| --- | --- | --- | --- |
|  | 2017/18 | 2018/19 | 2019/20 |
| Bedford Hospital NHS Trust | 7.7 | 10 (n)  | 11 (n) |
| England average | 13.7 | Not available | Not available |
| Best performing Trust | 0 | Not available | Not available |
| Worst performing Trust | 91.0 | Not available | Not available |

Table 20: Rate of Clostridium difficile infections - calculation

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

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.

|  |  |  |  |
| --- | --- | --- | --- |
|  | 2017/18 | 2018/19\* | 2019/20 |
| Bedford Hospital NHS Trust | 35.5 incidents | 39.1 | 54 |
| National average | 42.6 incidents | 44.5 | 49.8 | 49.8 |
| Best performing Trust | 24.2 incidents | 107.4 | 95.9 | 103.8 |
| Worst performing Trust | 124.0 incidents | 13.1 | 16.9 | 26.3 |

Table 21: Percent of patient safety incidents per 1,000 bed days

\*national data presented bi-annually

|  |  |  |  |
| --- | --- | --- | --- |
|  | 2017/18 | 2018/19\* | 2019/20\*\* |
| Bedford Hospital NHS Trust | 0.41% | 0.29% | 0.67% |
| National average | 0.37% | 0.3 | 0.3 | 0.3 |
| Best performing Trust | 0.20% | 0 | 0 | 0 |
| Worst performing Trust | 1.55% | 1.3 | 1.7 | 1.6 |

Table 22: Percent of patient safety incidents resulting in severe harm or death

National data presented bi-annually

\*\* Data refers to a six month period – April – September 2019

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 actions:

* 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 openness and transparency through duty of candour; analysis of the incident, identification of root causes; lessons learnt and action plans to prevent recurrence of the incident.

#### Serious incidents declared in 2019/20

During the financial year 2019/20, the Trust declared a total of 46 serious incidents which is the same number as the previous year.

A breakdown of the categories of Serious Incidents that occurred in 2019/20 is presented in the table below.

|  |  |
| --- | --- |
| Type of incident | Number of Serious incidents |
| Diagnostic incident including delay | 10 |
| Baby/child born in poor condition requiring transfer out | 6 |
| Delay in treatment | 5 |
| Safeguarding concern | 3 |
| Complication of procedure | 3 |
| Intrauterine death | 2 |
| Neonatal death | 1 |
| Maternal death | 1 |
| Adult collapse/death | 1 |
| Delayed escalation | 1 |
| Medication Incident | 1 |
| Fall | 1 |
| Potential media coverage | 2 |
| Unauthorised absence  | 1 |
| Total | 38 |

### Safety Thermometer (ST)

Safety thermometer was a tool used nationally to measure, monitor and analyse patient harm and ‘harm free’ care as a point prevalence survey once a month.

### Falls

#### Domain 5

In 2019/20 we reported one death from a fall. There were four severe harm falls and eight patients that suffered moderate harm. As this is a point prevalence survey carried out nationally it cannot be compared to the total number of falls reported earlier in this report.

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

|  |  |  |  |
| --- | --- | --- | --- |
|  | Jan 2018 | Jan 2019 | Jan 2020 |
| Rate per 1000 bed days Total harm cumulative | 1.22 | 1.05 | 1.19 |
| Rate per 1000 bed days Total falls | 5.46 | 4.78 | 5.11 |
| Number | 620 | 659 | 698 |

Table 24: Total harm from falls per 1,000 bed days:

The national rate is documented at 6.6 (National Falls Audit RCP 2015).

From the specified date every month; falls are reviewed over the previous 72hr period; safety thermometer looks at falls from two aspects, falls where patients sustained any level of harm and then the total of all falls that have occurred within the 72hr period.

The first graph looks at falls with harm sustained; we sit below the nation line of 0.8%, as a trust we have fluctuated above the national line on one occasion in the last year. The second graph looks at all falls within the 72 period, as a trust it fluctuates from 0.8% harm up to 3.6% harm on one occasion in the last 12 months.

From April 2020 Safety thermometer will be obsolete, in line with public consultation. There are future plans for nationally-produced replacement data to support improvement drawn from routinely collected sources

The National Audit of inpatient falls 2015 and 2017 identified the following areas that required improvement:

* Lying standing blood pressure measuring for all patients over 65 years old
* Vision assessment
* Delirium and dementia assessment

#### Falls reduction quality improvement program

The quality improvement program ‘Focus on Falls’ has continued throughout 2019-2020. An information station emphasising falls prevention has been implemented to highlight information to staff, patients and their relatives on strategies to reduce the risk of falls.

1. 2019 CQUINS (Commissioning for quality and innovation) Fall’s prevention strategy
2. The CQUIN framework supports improvements in the quality of servicers and the creation of new, improved patterns of care.
3. Lying and standing blood pressure recorded at least once.

No hypnotics or antipsychotics or anxiolytics given during stay OR rationale for giving hypnotics or antipsychotics or anxiolytics documented (British National Formulary defined hypnotics and anxiolytics and antipsychotics).

Mobility assessment documented within 24 hours of admission to inpatient unit stating walking aid not required OR walking aid provided within 24 hours of admission to inpatient unit.

### Pressure Ulcers (ST)

#### Domain 5

Pressure ulcers are one element within safety thermometer.

New guidance was published by NHSI in 2018 which was implemented in 2019. Pressure ulcers will be defined as; New Pressure Ulcers (NPU - previously known as hospital acquired pressure ulcers). The term avoidable and unavoidable are no longer in use. Safety thermometer categorisation has not been updated in line with the new guidance therefore Suspected Deep Tissue Injury (SDTI), and unstageable pressure ulcers are presumed category 3 and collated within these numbers.

The first graph looks at pressure ulcers that developed whilst the patient was in hospital; our harm rates have been between 0.27% - 2.52%. National Average has been between 0.89% - 1.11%, Bedford Hospital has fluctuated throughout the year.



The second graph looks at the point prevalence of all pressure ulcers including those present on admission and those that developed in hospital ; nationally harm is 4.6 – 5.16 %, as a Trust we sit at 4.38 – 8.79% harm,



### Quality improvement initiatives;

In addition to the initiatives established in 2018/19 the Trust has also implemented the following:

* Increase in hours for Tissue Viability Service allowing for more visibility on wards and validation of all new pressure ulcers
* Development of New Pressure Ulcer process for investigation, to provide additional guidance for staff including specific time frames to further ensure timely investigation and learning.
* Development of Tissue Viability Referral Guidance to ensure appropriate referrals allowing more time for educational role of the Tissue Viability Service.
* Quality assurance audits in regards to accurate completion of investigations – commencement of random selection of completed by Tissue Viability Service monthly
* Annual audit of the Trust foam mattresses demonstrated a decline in condemned mattresses, showing appropriate checking and usage.
* An audit of appropriate use of mattresses, results being compiled to ascertain appropriate usage, will identify if further training in application of dynamic mattresses is required.
* The Tissue Viability Service remains involved in the Multidisciplinary Foot Team and regularly attend weekly meetings to review inpatient diabetic patients with extensive and complex foot ulcers (including pressure ulcers) in collaboration with vascular, podiatry and endocrine specialties.

#### Training;

In addition to the initiatives established in 2018/19 the Trust has also implemented the following

* Development of new power point presentations, work booklets and information trolley.
* Completion of 100 Day Pressure Ulcer Challenge – providing focused learning around pressure ulcer prevention over this period

Actions for next year include:

* The tissue viability service has secured further study days for wound assessment quarterly for the next financial year for Trainee Nursing Associates, Year 3 Student Nurses, Nurses and Doctors.
* Re-launch of the Tissue Viability Service – an event highlighting the service, and all provisions available to clinical staff.
* Change in reporting and investigation process to ensure even faster learning and ownership from clinical areas.
* Focus on moisture associated skin damage with collaboration of countenance leads
* Continued collaborative working with TVN at Luton and Dunstable Hospital, especially as part of a merged trust
* Recommencement of Newsletter to update and inform staff April 2020
* Implement a MDT collaborative meeting with community TVNS, Acute TVNs, Vascular, plastics and dermatology nurses to improve quality of care, reducing risks and increasing patient satisfaction and use of current resources.

### Drug incidents

#### Domain 5

There were three serious incidents that involved medication issues declared in 2019/20. The three incidents were relating to different drugs/themes as follows:

* Delay in treatment of patient in ED (abdominal pain and sepsis)
* Delay in diagnosis and management of necrotising fasciitis
* Omission of critical medicine (Tacrolimus)

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

Delay in treatment of patient in ED (abdominal pain and sepsis)

* Review of the hospital policy on Entonox
* Case discussion to be shared locally through team meetings

Delay in diagnosis and management of necrotizing fasciitis

* Development of Trust guideline/pathway for the management of suspected necrotizing fasciitis
* Case discussion locally through team and quality meetings

Omission of critical medicines (Tacrolimus)

* Currently under investigation.

**Highlights of Medication Safety work from 2019/20:**

* Drug shortages have been an ongoing medication safety issue in 2019/20 with shortages including diamorphine injection, Epipens and ranitidine tablets. This has presented challenging circumstances to provide patients with the treatment they require.
* A review of medication incidents showed that patients were frequently not receiving their opioid patches appropriately, either due to not being prescribed on admission or the old patch not being removed. The Medication Safety Group has undertaken the following as a result:
	+ Addition of ‘check for patch’ to the Trust skin bundle
	+ Patient information leaflet developed
	+ Liaison with primary care to ensure education of patient when initiated on a patch
	+ Shared learning from the incidents including in the medication safety newsletter

**Ongoing Medication Safety work:**

* Work is ongoing around omitted medications within the hospital, with a specific focus on critical medicines.
* Figures are now able to be reported on patients who receive medication without their allergy status being recorded. These patients will be flagged to the ward pharmacist daily to ensure an allergy status is recorded as soon as possible. The Medication Safety Group are now considering how to use this data to improve patient safety.

### Never events

#### Never Events declared in 2019/20:

The Trust declared 0 Never Events in 2019/20 compared to 6 Never Events in 2018/19. This is huge improvement for the Trust and reflects the success of the patient safety improvement work programme in theatres in relation to the use, monitoring and implementation of the WHO Surgical Safety Checklist.

### Complaints

The Trust has a statutory obligation for the handling and investigation of complaints and concerns, to ensure that they are dealt with efficiently, are properly investigated and that immediate learning and action is taken where necessary. Supporting the formal elements of complaints, the Trust has a Patient Advice and Liaison Service (PALS) who work with staff, patients, relatives and carers to try and quickly resolve concerns informally and at local service level wherever possible.

A formal complaint involves a thorough investigation following which the Chief Executive responds directly to the person who made the complaint. 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 to complete an investigation and respond to the complainant. Within the past 12 months, the Trust has been meeting an average response time of 29 working days; showing a year on year improvement.

The Trust endeavours to always provide a timely and satisfactory response to every complaint it receives and offers the opportunity to access an independent complaints advocacy service free of charge should complainants wish to have autonomous support at any time through the complaints process.

There are occasions when the person who complains 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 staff. If the Trust’s efforts to resolve a complaint are deemed unsatisfactory they are advised that they can refer their complaint to the Parliamentary and Health Services Ombudsman (PHSO).

**Overview**

Last year the Trust reported a downward trend in complaints over the previous years and this continues to remain stable. Over the past year, The Trust has maintained efforts to develop its processes and share learning from our complaints in the following ways:

* Staff training at clinical update
* Monthly Midwifery update training on PALS and complaints
* Management of concerns through PALS to ensure quick resolution
* Identify and share themes to inform staff of trends and areas where actions/service improvements can be made.
* Triangulating complaints and concerns within the Trust through the weekly “Sharing Risk” meeting.
* Supporting communication requirements in line with Accessible Information Standards.
* ‘Look, Listen and Learn’ messages for staff are highlighted in the Chief Executive’s weekly newsletter
* Doctors training
* Complaints managers forum
* Reporting to the quarterly Learning Disability forum
* Reporting to the End of Life Steering Group
* Attendance at local listening events to receive feedback from the community

#### Parliamentary and Health Service Ombudsman (PHSO)

The PHSO was set up by Parliament to provide an independent complaint handling service for complaints unresolved by the NHS in England and UK government departments. Their role is to make final decisions on complaints where someone believes there has been injustice or hardship because an organisation has not acted properly, or has given a poor service and not put things right. The Ombudsman can recommend that organisations provide explanations, apologies and financial remedies to service-users, and take action to improve services. On their website they have published their tariff for financial remedy for injustice (on a scale of levels 1 – 6) to inform stakeholders how they decide upon the scale of remedy.

In February 2019 the PHSO, in conjunction with NHSR (National Health Service Resolution – formerly the Litigation Authority) issued information to NHS Trusts on the respective roles of the PHSO and NHSR in resolving NHS complaints and claims and explaining how their services overlap and interact.

They are independent of each other, but share a commitment to help the NHS respond more effectively when things go wrong. They are working together to improve the interaction between NHS complaints and claims systems.

In 2019/20 the Trust continued to see a downward trend in complaints investigated by the PHSO with only one complaint raised to and remaining under investigation. We also saw a complaint closed by the PHSO, opened in the previous year and this was not upheld.

This compares to the previous year where three complaints were investigated and historical case was reopened. The year before saw six complaints investigated. This downward trend highlights the efforts to provide robust and transparent responses, in a timely manner to those who use our services.

#### 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 effective 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 and a formal response.

In 2019/20 the Trust registered 1066 (not accurate to end of year number and will be higher) PALS concerns compared to 1086 the previous year. This highlights a reliable and easily accessible service.

#### Compliments

The Trust is fortunate to receive a significant number of compliments including feedback, thank you cards, gifts and donations. 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 records compliments notified through PALS on the Datix system.

#### Learning from complaints and PALS

* Response letters from the Chief executive and the PALS team now incorporate the use of a learning table to clearly identify actions for improvement which are shared with relevant staff.
* A monthly quality improvement newsletter (QI) is circulated to all staff by email and hard copies are taken to each department by volunteers and this often incorporates learning from complaints.
* 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 participates in regional doctors’ training focusing on complaints, claims and statement writing.
* The team has created a learning disability friendly PALS and Complaints leaflet, seeking advice and incorporating ideas from our local learning disability forum.
* The complaints team continues to engage with the Parliamentary and Health Service Ombudsman, attending workshops to participate in their improvement strategies.

#### Next steps

* To continue working to below a 30 working day average response time to complaints.
* To complete an annual review of complaint satisfaction surveys.
* Encouraging staff through training to resolve concerns locally.
* To continue to share and embed the learning from complaints/concerns and claims through reporting, training and trust-wide cultural awareness.
* To continue attendance at local listening events to ensure that feedback is acted upon.

### 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 2020/21 the Trust will continue to:**

* Review how Friends and family test (FFT) feedback information, especially the comments are gathered and used to improve the patient experience. Implement national new guidance and formats for FFT by April 2020.
* Develop a Programme of engaging with difficult to reach patients to e.g. in the care of the elderly, young people, people with dementia to ensure their feedback is received and acted upon

## National surveys

### Inpatient cancer survey 2019;

The national inpatient cancer survey highlighted that patients with cancer feel they need more information during their stay. The outcomes of this survey have been shared with key stakeholders. Liaison with the STP cancer leads have also been sought and are planned during 2020/2021. A listening event has been held for prostate cancer patients and further sessions are being planned.

### Maternity survey 2019;

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

* Found partner was able to stay with them as long as they wanted
* The recent maternity survey results how that 75% of women nationally are able to have partners staying in the inpatient setting.
* Action Seek the views of local women to understand their wishes around having partners staying
* Received help and advice about feeding their baby

The maternity service at BHT is fully accredited with standards set by BFI (Unicef) and is currently working with the Maternity Voices Partnership (MVP) to improve feeding support to women.

Action: Continue to attend workshops run by the Maternity Voices Project. Continue to work with standards consistent with BFI (Unicef) in preparation for reaccreditation in October 2020.Monitor audit of standards via governance meetings.

* Able to get help when needed (after the birth)
* This comment could relate to experience on delivery suite or the ward in the immediate postnatal period.
* There is an expectation that call bells are answered straight away.

Action: An audit of call bell response times will be carried out.

* Had enough time to ask questions during antenatal check-ups.
* Discharged without delay

The standard time for a routine antenatal appointment is 15 minutes in the community area. The standard appointment time for a antenatal check up in the obstetric antenatal clinic is 10 minutes. Improving access to obstetricians in an appropriate timeframe for women is an ongoing plan. There is national requirement for 30% of women to be booked onto a CoC pathway by March 2020.

Action: Explore potential for maternity Support workers (Band 3) to support midwives in community antenatal clinics. Continue with project work to introduce an electronic referral system from community midwife to obstetrician in order to facilitate earlier appointments with obstetricians. Continue with the introduction of continuity of carer teams so that there is more effective communication between the midwife and woman at each interaction. Women will not usually have to repeat their stories.

Discharged without delay

Delays are sometimes due to awaiting medication to take home or paediatrician to perform checks on babies. Sometimes it is volume of women and babies requiring discharge that is 10-15 per day.

### Children and young people’s survey 2018;

This report shows that the vast majority of the outcomes were within the expected outcome, compared with national data.

The survey describes better than most trusts;

* ‘Did the hospital answer your questions?’ for 8-15 year olds
* ‘Did a member of staff give you advice on how to look after yourself after you went home?’ for 8-15 year olds

Significantly higher scores compared to the 2016 survey;

* ‘Were you able to ask staff any questions you had about your child’s care?’ for 0-15 year olds (Patients or Parents)
* Did a member of staff give you advice on how to look after yourself after you went home?’ for 8-15 year olds (Patients or Parents)

One response was noted to be worse than most other trusts

* ‘Did new members of staff treating your child introduce themselves?’ for 0-7 year olds

An action plan has been commenced to address CQC survey and Picker reports for this survey ;

* Parent’s facilities overnight.

These have been reviewed and on recent divisional quality meeting feedback at present is that parents are asking for facilities, such as recliner chairs, to be provided so they may rest next to the children too. The division is exploring cost and provision of these chairs

* Staff playing with children.

The division is monitoring feedback from children. Currently there are some vacancies in the play leaders and these are being actively recruited too.

* Children feeling there is not enough things to do in hospital

The trust is reviewing the provision of Wi-Fi and entertainment, this feedback was provided to the working group and options for enhanced package for children’s entertainment being considered.

The children’s indoor play area is being upgraded and is expected to be completed within 6 months

* Admission dates not being changed.

### Inpatient survey 2018

The results for this survey indicated discharge planning, communication and pain control were required action.

NHSi Improving Patient experience framework is in progress. A workshop using this tool was conducted in April 2019. The outcomes from this will inform the provision of a patient experience strategy for BHT.

A working group is reviewing the provision of discharge documentation to improve provision of discharge letter for patients and their GP’s.

The Equality, Diversity & Dignity Committee has recently compared the survey samples with the inpatient population to establish if this representative of the annual in patient profile. This was in terms of ethnicity and sex. The findings were that the sample largely reflected the profile.

Review of the patient flow though the hospital is ongoing and since this survey surgical wards and medical wards have been reconfigured to reduce the number of specialty outliers, this should positively impact on the patients treatment planning and communication between medical staff and patients.

### 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 2019 survey was 44% (1269 staff) which is similar to the 2018 against an overall national response rate median of 47% trust. The staff engagement score of 7.0 is average across acute trusts.

In terms of overall results from the Picker cohort, the following should be noted:

|  |  |
| --- | --- |
|  | **Top 5 scores (compared to average)** |
| 63% | Q4f. Have adequate materials, supplies and equipment to do my work |
| 51% | Q4e. Able to meet conflicting demands on my time at work |
| 73% | Q16b. In last month, have not seen errors/near misses/incidents that could hurt patients/service users |
| 64% | Q17d. Staff given feedback about changes made in response to reported errors/near misses/incidents |
| 40% | Q19c. Appraisal/performance review: Clear work objectives definitely agreed |

|  |  |
| --- | --- |
|  | **Most improved from last survey**  |
| 71% | Q7c. Able to provide the care I aspire to |
| 45% | Q10c. Don't work any additional unpaid hours per week for this organisation, over and above contracted hours |
| 63% | Q4f. Have adequate materials, supplies and equipment to do my work |
| 73% | Q16b. In last month, have not seen errors/near misses/incidents that could hurt patients/service users |
| 84% | Q16a. In last month, have not seen errors/near misses/incidents that could hurt staff |

|  |  |
| --- | --- |
|  | **Bottom 5 scores (compared to average)** |
| 55% | Q10b. Don't work any additional paid hours per week for this organisation, over and above contracted hours |
| 62% | Q19f. Appraisal/performance review: training, learning or development needs identified |
| 67% | Q21d. If friend/relative needed treatment would be happy with standard of care provided by organisation |
| 50% | Q23b. I am unlikely to look for a job at a new organisation in the next 12 months |
| 56% | Q23c. I am not planning on leaving this organisation. |

|  |  |
| --- | --- |
|  | **Least improved from last survey**  |
| 48% | Q4c. Involved in deciding changes that affect work |
| 70% | Q4a. Opportunities to show initiative frequently in my role |
| 67% | Q21d. If friend/relative needed treatment would be happy with standard of care provided by organisation |
| 67% | Q20. Had training, learning or development in the last 12 months |
| 56% | Q23c. I am not planning on leaving this organisation. |

In terms of trend data, the following analysis applies:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|   | 2015 | 2016 | 2017 | 2018 | 2019 |
| Often/always look forward to going to work | 67% | 62% | 62% | 63% | 63% |
| Often/always enthusiastic about my job | 82% | 77% | 75% | 78% | 75% |
| Time often/always passes quickly when I am working | 81% | 81% | 81% | 78% | 78% |
| Always know what work responsibilities are | 91% | 91% | 91% | 90% | 90% |
| Feel trusted to do my job | 97% | 91% | 92% | 93% | 94% |
| Able to do my job to a standard I am pleased with | 86% | 85% | 82% | 82% | 80% |
| Opportunities to show initiative frequently in my role | 75% | 70% | 72% | 74% | 70% |
| Able to make suggestions to improve the work of my team/dept | 78% | 73% | 73% | 73% | 71% |
| Involved in deciding changes that affect work | 51% | 52% | 51% | 54% | 48% |
| Able to make improvements happen in my area of work | 57% | 57% | 54% | 56% | 53% |
| Able to meet conflicting demands on my time at work | 50% | 47% | 50% | 47% | 51% |
| Have adequate materials, supplies and equipment to do my work | 67% | 62% | 59% | 58% | 63% |
| Enough staff at organisation to do my job properly | 39% | 35% | 34% | 32% | 32% |
| Team members have a set of shared objectives | 74% | 74% | 70% | 72% | 71% |
| Team members often meet to discuss the team's effectiveness | 67% | 58% | 58% | 58% | 56% |
| I receive the respect I deserve from my colleagues at work | - | - | - | 72% | 72% |
| Satisfied with recognition for good work | 57% | 53% | 52% | 55% | 57% |
| Satisfied with support from immediate manager | 71% | 68% | 64% | 68% | 69% |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|   | 2015 | 2016 | 2017 | 2018 | 2019 |
| Satisfied with support from colleagues | 83% | 82% | 81% | 82% | 81% |
| Satisfied with amount of responsibility given | 80% | 78% | 72% | 73% | 76% |
| Satisfied with opportunities to use skills | 75% | 78% | 71% | 73% | 73% |
| Satisfied with extent organisation values my work | 49% | 46% | 45% | 47% | 49% |
| Satisfied with level of pay | 39% | 37% | 30% | 37% | 36% |
| Satisfied with opportunities for flexible working patterns | 57% | 58% | 54% | 56% | 54% |
| I have realistic time pressures | - | - | - | 20% | 22% |
| I have a choice in deciding how to do my work | - | - | - | 55% | 57% |
| Relationships at work are unstrained | - | - | - | 43% | 44% |
| Satisfied with quality of care I give to patients/service users | 91% | 85% | 80% | 79% | 82% |
| Feel my role makes a difference to patients/service users | 92% | 91% | 90% | 91% | 90% |
| Able to provide the care I aspire to | 73% | 73% | 67% | 65% | 71% |
| My immediate manager encourages me at work | - | - | - | 66% | 66% |
| Immediate manager can be counted on to help with difficult tasks | 76% | 71% | 69% | 69% | 71% |
| Immediate manager gives clear feedback on my work | 60% | 57% | 58% | 60% | 62% |
| Immediate manager asks for my opinion before making decisions that affect my work | 57% | 51% | 52% | 53% | 54% |
| Immediate manager supportive in personal crisis | 74% | 74% | 70% | 72% | 72% |
| Immediate manager takes a positive interest in my health & well-being | 69% | 65% | 64% | 66% | 65% |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|   | 2015 | 2016 | 2017 | 2018 | 2019 |
| Immediate manager values my work | 72% | 71% | 67% | 71% | 72% |
| I know who senior managers are | 84% | 82% | 83% | 85% | 82% |
| Communication between senior management and staff is effective | 48% | 44% | 41% | 41% | 41% |
| Senior managers try to involve staff in important decisions | 39% | 35% | 34% | 33% | 34% |
| Senior managers act on staff feedback | 37% | 32% | 32% | 32% | 33% |
| Don't work any additional paid hours per week for this organisation, over and above contracted hours | 57% | 57% | 58% | 55% | 55% |
| Don't work any additional unpaid hours per week for this organisation, over and above contracted hours | 42% | 47% | 44% | 40% | 45% |
| Organisation definitely takes positive action on health and well-being | 37% | 37% | 34% | 28% | 27% |
| In last 12 months, have not experienced musculoskeletal (MSK) problems as a result of work activities | 80% | 74% | 76% | 71% | 69% |
| Not felt unwell due to work related stress in last 12 months | 76% | 69% | 60% | 62% | 62% |
| In last 3 months, have not come to work when not feeling well enough to perform duties | 41% | 29% | 42% | 45% | 44% |
| Not felt pressure from manager to come to work when not feeling well enough | 77% | 74% | 73% | 74% | 73% |
| Not felt pressure from colleagues to come to work when not feeling well enough | 78% | 76% | 76% | 80% | 79% |
| Not put myself under pressure to come to work when not feeling well enough | 8% | 11% | 9% | 10% | 8% |
| Not experienced physical violence from patients/service users, their relatives or other members of the public | 91% | 85% | 86% | 85% | 88% |
| Not experienced physical violence from managers | 99% | 99% | 99% | 99% | 100% |
| Not experienced physical violence from other colleagues | 99% | 97% | 98% | 98% | 99% |
| Last experience of physical violence reported | 57% | 68% | 65% | 68% | 66% |
| Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public | 72% | 70% | 71% | 71% | 71% |
| Not experienced harassment, bullying or abuse from managers | 90% | 88% | 87% | 86% | 86% |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|   | 2015 | 2016 | 2017 | 2018 | 2019 |
| Not experienced harassment, bullying or abuse from other colleagues | 84% | 83% | 83% | 82% | 81% |
| Last experience of harassment/bullying/abuse reported | 53% | 49% | 51% | 46% | 46% |
| Organisation acts fairly: career progression | 89% | 86% | 81% | 83% | 82% |
| Not experienced discrimination from patients/service users, their relatives or other members of the public | 95% | 92% | 93% | 93% | 93% |
| Not experienced discrimination from manager/team leader or other colleagues | 96% | 92% | 89% | 91% | 93% |
| In last month, have not seen errors/near misses/incidents that could hurt staff | 85% | 85% | 84% | 80% | 84% |
| In last month, have not seen errors/near misses/incidents that could hurt patients/service users | 77% | 75% | 73% | 68% | 73% |
| Last error/near miss/incident seen that could hurt staff and/or patients/service users reported | 91% | 95% | 94% | 97% | 94% |
| Organisation treats staff involved in errors/near misses/incidents fairly | 52% | 53% | 51% | 56% | 57% |
| Organisation encourages reporting of errors/near misses/incidents | 84% | 88% | 86% | 88% | 88% |
| Organisation takes action to ensure errors/near misses/incidents are not repeated | 65% | 69% | 70% | 71% | 74% |
| Staff given feedback about changes made in response to reported errors/near misses/incidents | 51% | 53% | 61% | 63% | 64% |
| Know how to report unsafe clinical practice | 93% | 97% | 96% | 95% | 93% |
| Would feel secure raising concerns about unsafe clinical practice | 66% | 70% | 73% | 70% | 69% |
| Would feel confident that organisation would address concerns about unsafe clinical practice | 58% | 59% | 60% | 58% | 58% |
| Had appraisal/KSF review in last 12 months | 75% | 79% | 84% | 87% | 84% |
| Appraisal/review definitely helped me improve how I do my job | 31% | 26% | 26% | 29% | 28% |
| Appraisal/performance review: Clear work objectives definitely agreed | 41% | 39% | 37% | 39% | 40% |
| Appraisal/performance review: definitely left feeling work is valued | 38% | 32% | 28% | 35% | 36% |
| Appraisal/performance review: organisational values definitely discussed | 41% | 35% | 33% | 38% | 39% |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|   | 2015 | 2016 | 2017 | 2018 | 2019 |
| Appraisal/performance review: training, learning or development needs identified | 74% | 73% | 63% | 64% | 62% |
| Definitely supported by manager to receive training, learning or development identified in appraisal | 54% | 52% | 50% | 59% | 57% |
| Had training, learning or development in the last 12 months | 70% | 69% | 68% | 70% | 67% |
| Care of patients/service users is organisation's top priority | 79% | 78% | 74% | 77% | 79% |
| Organisation acts on concerns raised by patients/service users | 80% | 74% | 76% | 75% | 75% |
| Would recommend organisation as place to work | 68% | 65% | 62% | 63% | 61% |
| If friend/relative needed treatment would be happy with standard of care provided by organisation | 78% | 72% | 67% | 71% | 67% |
| Patient/service user feedback collected within directorate/department | 91% | 91% | 86% | 90% | 89% |
| Receive regular updates on patient/service user feedback in my directorate/department | 63% | 64% | 70% | 63% | 63% |
| Feedback from patients/service users is used to make informed decisions within directorate/department | 60% | 57% | 63% | 60% | 60% |
| I don’t often think about leaving this organisation | - | - | - | 46% | 44% |
| I am unlikely to look for a job at a new organisation in the next 12 months | - | - | - | 53% | 50% |
| I am not planning on leaving this organisation. | - | - | - | 60% | 56% |

In terms of the overall national results, the Trust has performed better than average in five of the 11 themes, average in four and slightly below average in two theme as the graph shows below. The score for safer environment (violence) of 9.6 was in the best score category.



Figure 8: 2019 Staff Survey results - Overview

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 and disability to identify whether the reported staff experience is different for different groups within the workforce.

The Trust 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 20/21 will incorporate the actions arising.

The staff survey data clearly shows in the report that 84% of staff have received an appraisal, which is in line with monthly workforce information published internally to the organisation. Our internal target is 90% and the Trust supports managers with reminders, meetings and training support in moving towards the 90% target.

## Seven Day Services Clinical Standards

### Seven Day Services

The national Medical Director for NHS England introduced ten key standards to ensure that inpatients have equitable access to the full spectrum of clinical care every day of the week. Delivery was intended to reduce variation in mortality rates, improve patient experience, and reduce length of stay and readmissions.

Four standards were identified as priority for delivery. The requirements to meet each individual standard have been refined over the last 2 years by NHS England and NHS Improvement.

From November 2018, NHS Improvement moved from central reporting and analysis to a Trust Board Assurance Framework. Biannual completion of a self-assessment template is required which is then submitted to NHS England/Improvement for national benchmarking.

The ten clinical standards, which should apply consistently seven days a week have been tabled previously at Trust Board (most recently June 2019). The four priority clinical standards are highlighted below. This applies to both locally commissioned and specialised services (for Bedford Hospital this relates only to vascular surgery). Trusts are asked to consider the remaining six standards (collectively known as the ‘7DS for continuous improvement’) as an enabler to delivering the priority standards.

### Local re-audits and self-assessment – October 2019

Re-audits in high priority specialties (focussing on Standards 2 and 8 were) undertaken using a 1 week sample in late September/early October. A self-assessment against standards 5 and 6 was undertaken October 2019. The NHSI template is attached. Note the RAG rating is set by NHSI; missing the standard triggers a ‘red’ rating. NHSI have advised that the template is under review as it cannot show incremental progress.

### Clinical Standard 2

All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.

#### Acute medicine

Sample size: 103

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | May 2018 | August 2018 | January 2019 | April 2019  | October 2019 |
| Weekday | 69% | 70% | 79% | 76% | 88% |
| Weekend | 68% | 77% | 95% | 90% | 86%  |

Overall 14 hour review standard met in 87% of acute medicine admissions.

#### General surgery

Sample size: 28

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | May 2018 | January 2019 | April 2019  | October 2019 |
| Weekday | 50% | 59% | 50% | 70% |
| Weekend | 33% | 44% | 29% | 62% |

#### Vascular surgery

Sample size: 26

|  |  |  |  |
| --- | --- | --- | --- |
|  | May 2018 | April 2019  | October 2019 |
| Weekday | 100% | 100% | 71% |
| Weekend | No results | 50% | 80% |

NB. Random sample of 30% of all emergency admissions between 1st August 2019 and 20th October 2019

#### Trauma and orthopaedics

Sample size: 6

|  |  |  |  |
| --- | --- | --- | --- |
|  | May 2018 | April 2019  | October 2019 |
| Weekday | 67% | 67% | 75% |
| Weekend | 50% | 100% | 50% |

NB. Small sample size

#### Paediatrics

Sample size: 33

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | May 2018 | January 2019 | April 2019  | October 2019 |
| Weekday | 53% | 88% | 64% | 71% |
| Weekend | 50% | 50% | 100% | 77% |

NB. Sample taken between 19th September 2019 and 12th October 2019

#### Overall trust results - October 2019

|  |  |  |
| --- | --- | --- |
|  | 1st consultant review within 14 hours | 1st consultant review beyond 14 hours  |
| Weekday | 79% | 21% |
| Weekend | 78% | 22% |
| Trust total  | 78% | 22% |

### Clinical Standard 5

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

#### CT

24/7 service weekdays and weekends.

#### Echocardiography

No out of hours service except in Critical Care or Coronary Care (where there is ad hoc Consultant Cardiologist cover). There is a networked service with Papworth for patients requiring emergency transfer for treatment but not for diagnostic echo. The department has consulted existing staff with a view to implementation of a day time weekend service. Due to capacity issues and the need to recruit an additional technician the weekend service is ad hoc and voluntary. An out of hours service for critical patients (<1 hr) will not be feasible with current staffing and would require resident echo technicians. This standard is not met.

#### Microbiology

24/7 service weekdays and weekends.

#### MRI

 A service for spinal cord compression has been in place 08:00-20:00, 7 days a week since September 2018. Out of hours imaging for these patients is reported by the neurosurgeons at the regional centre. Networked access is available from Addenbrooke’s for patients requiring imaging outside of this time. The department is scheduled to commence out of hours MRI (08:00-20:00, 7 days a week) for other inpatient work. This had been due to commence end June 2019 but has been delayed due to IT issues linking to the outsourcing company. Overall the standard is partially met.

#### Ultrasound

Progress has been made on this standard in 2019. From July 2019 there is a sonographer-run ultrasound service which operates 08:00-11:30 Saturday and Sunday, supported by the on-call Consultant Radiologist. Outside of these hours the on-call Consultant Radiologist is available for emergency scans only; in practice the case mix requiring overnight imaging is more likely to require CT than ultrasound. Overall the standard is partially met but not for critical patients. The latter would require a resident sonographer.

#### Upper GI Endoscopy

24/7 service weekdays and weekends.

### Clinical Standard 6

Hospital inpatients must have timely 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. These interventions would typically be:

* Critical care. On site.
* Primary PCI. Off site via formal arrangement.
* Cardiac pacing. Mix of on/off site by formal arrangement.
* Thrombolysis for stroke. Off site via formal arrangement.
* Emergency general surgery. On site.
* Interventional endoscopy. On site.
* Interventional radiology. No.
* Renal replacement. Mix of on/off site by formal arrangement.
* Urgent radiotherapy. Off site not via a formal arrangement.

### Clinical Standard 8

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 and that review can be delegated.

#### April 2019 results

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Number of daily reviews required across sample | Daily review carried out by consultant | Daily reviews carried out by Registrar | Daily review carried out by CT/FY  | No review |
| Acute medicine | 117 | 67% | 7% | 8% | 19% |
| General surgery | 112 | 75% | 24% | 0% | 1% |
| T&O | 55 | 71% | 0% | 9% | 20% |
| Vascular | 21 | 95% | 5% | 0% | 0% |
| Paediatrics | 24 | 67% | 25% | 4% | 4% |

October 2019 results

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Number of daily reviews required across sample | Daily reviews carried out by consultant | Daily reviews carried out by Registrar | Daily review carried out by CT/FY  | No review |
| Acute medicine | 109 | 74% | 8% | 4% | 11% |
| General surgery | 65 | 69% | 26% | 1% | 4% |
| T&O | 26 | 69% | 8% | 11% | 11% |
| Vascular | 92 | 76% | 7% | 7% | 9% |
| Paediatrics | 22 | 77% | 14% | 0% | 9% |

### National challenges

The national strategy was highlighted in ‘Seven day hospital services: challenges and solutions’ (NHS Improvement, December 2017). This focussed mainly on Clinical Standard 2 and included actions such as prioritising patients for review, continuous rounding, defining pathways, which do not require consultant review and more difficult system actions, such as changing the time of GP home visits to allow referrals to be admitted in office hours.

### Local challenges

#### Clinical Standard 2

This should be achievable within current resources but this requires appropriate job planning. Consultants are responsible for ensuring that new admissions are prioritised for review.

#### Acute medicine

Weekend performance against this standard has slightly declined since the previous audit but weekday performance has improved to 88%. A secondary indicator of CS2 – formal documentation of the management plan discussion with the patient continues to improve from 20% in May 2018 to 70% in April 2019 with October 2019 performance sitting at 92%.

#### General surgery and vascular surgery

The audit results for general and vascular surgery have improved at the weekend and weekdays in general surgery since April 2019. In the recent audit, however, 21% of general surgery patient records and 14% of vascular surgery patient records did not have the time and/or date of the first consultant review documented correctly.

Actions required:

* Division to ensure all doctors are aware of the responsibility to accurately document the time and date of every patient review

#### Clinical Standard 5

* Further progress has been made with improved access to MRI and ultrasound.

#### Clinical Standard 6

There remains a regional and national challenge due to a shortage of interventional radiologists and the service specification mandated by specialised commissioners and the GIRFT report on vascular services. This cannot be delivered within the ICS and serious concerns are shared by other local organisations. Negotiations are ongoing with Addenbrooke’s and other providers around a networked regional interventional radiology service. The current position as of September 2019 is that there is a proposed regional service at Addenbrooke’s which providers are being asked to sign up to. However, for Bedford there is no cover for vascular interventional radiology with this service which is an unacceptable clinical risk. Concerns have been highlighted to NHS Improvement and NHS England.

#### Clinical Standard 8

Merger will allow the opportunity to plan services to deal with Clinical Standard 8, in particular medical sub-specialty review 7 days a week. This will require a further increase in consultant staff as part of a wider clinical team at individual specialty level. Financial considerations aside, the ability to recruit remains a significant challenge.

**Next Steps**

The board assurance process involves biannual completion of the self-assessment template, reporting to board and subsequent submission to NHS Improvement for national benchmarking.

## Statements of assurance from the board

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

During 2019/20, Bedford Hospital NHS Trust provided 43 relevant health services and sub-contracted 10 relevant health services.

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 2019/20 represents 100 percent of the total income generated from the provision of relevant health services by Bedford Hospital NHS Trust for 2019/20.

### Annex one: services provided by Bedford Hospital NHS Trust in 2019/20

|  |  |
| --- | --- |
| Acute Admissions Unit | Lower Gastro-Intestinal |
| Acute Emergency Care Assessment Unit | Medical Oncology |
| Audiology | Microbiology\* |
| Accident and Emergency | Midwifery |
| Blood Transfusion | Neonatal |
| Breast Surgery | Nephrology\*\* |
| Cardiology | Neurology |
| Cardiac Catheterisation Suite | Obstetrics |
| Chemical Pathology\* | Ophthalmology\*\*\* |
| Colorectal Surgery | Oral Maxillofacial (OMF) |
| Critical Care Medicine (CC) | Orthodontics |
| Dermatology | Orthotics\*\*\*\*\* |
| Diabetic Medicine | Occupational Therapy |
| Ear Nose and Throat (ENT) | Paediatrics |
| Accident and Emergency | Pain Management |
| Elderly Care | Phlebotomy |
| Endocrinology | Pharmacy |
| Endoscopy Unit | Physiotherapy |
| Gastroenterology | Plastic Surgery |
| General Medicine | Podiatry (mainly for diabetic outpatients but also Rheumatology and T&O outpatients)\*\*\*\* |
| General Pathology\* | Retinal Screening |
| General Surgery | Rheumatology |
| Gynaecology | Screening Services - AAA, Diabetic Retinopathy, Bowel, Cervical Screening |
| Hepatology | Speech and Language Therapy\*\*\*\* |
| Haematology\* | Trauma and Orthopaedics |
| Histopathology\* | Theatres |
| Immunopathology\* | Tunable Dye Laser Treatment |
|  | Upper Gastro-Intestinal |
|  | Urgent treatment centre |
|  | Urology |
|  | Vascular |

\* 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 East London NHS Foundation Trust

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

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

Due to COVID-19 national guidance was issued that released trust’s from securing an assurance statement from external stakeholders.



#### Comments from Healthwatch Central Bedfordshire (HWCB) - Bedford Hospital Quality Account 2019/20

Overall, the report from the Trust is disappointing. The document is not well written; it is very difficult to follow, and difficult to really understand what quality improvements the trust has made and how they measure against local and national benchmarks.

Firstly, relating to layout of the report; the numbering in the ‘Table of Contents’ does not match the actual paragraphs and pagination is required in order to effectively assist any review. In addition, as HWCB commented in last year’s report, other points relating to layout and associated matters are that several acronyms do not make the list in Annex 5. For example, in the early part of the report GDE, MDT, PAT and ICE are unexplained which the general public will not understand. The ‘Table List’ is inaccurate as the numbers assigned (in the main text) do not tally with the Table List. Several have no data for 2019/20 for example those shown in the text as Tables 14 and 15 (or No.15 and 16 in the List of Tables), making any review meaningless. Whilst we appreciate that this is a desk-top publishing issue that will most likely be resolved in the final draft it has not helped this review.

Unfortunately, the quality of the document appears to be reflective of what appears to be ‘an overarching approach to quality’, in that quality improvement does not appear to sit at the heart of the organisation as a high priority.

In addition, the culture of making things better for patients, whilst there are some examples, does not come across clearly and is not supported by measurable outcomes of success. The use of statistical monitoring does in the most part, not provide robust evidence of the impact of the quality improvement projects on the delivery, experience and outcomes, for individuals. It is disappointing to note that on several occasions the Trust is waiting for the publication of national data to understand what improvements need to be made.

#### 2019/20 Quality Priorities

In relation to the quality goals for 2019/20 and in particular the patient safety priority GDE, it is not entirely clear from the document what measures were implemented and successful, what remains outstanding to implement, and what significant improvements these have contributed to patient care.

In relation to speeding up diagnosis of cancer, it appears some considerable improvement has been made in patient pathways, in terms of speed of diagnosis, which should be commended.

Whilst commending the quality improvement related to patient experience in 2019/20, it is of concern that only two listening events were held, with small numbers of attendees, so it is difficult to determine how representative these were of the population, and to the approaches to listening and engaging with public, patients, their families and carers, to routinely offer qualitative feedback to help shape and design services. It is disappointing to see that the only significant change was a new and improved website. Whilst the Trust stated that the learning from the events will support the 2020/2021 plans this does not feature as a goal for next year. It is disappointing that the Trust is waiting for national data to be published to understand where to focus its improvements to the personal needs of patients.

 Achievements

Relating to achievements highlighted in the report, HWCB has noted:

▪ That the trust has maintained its performance in relation to the 95% risk assessment for VTE. ▪ There has been a downward trend in complaints and improvement in the complaint’s response times. ▪ The appointment of four ‘Speak up’ Champions and ‘Peer2peer’ listeners to support staff in speaking up is welcomed.

#### Patient and Staff Surveys/Data

Clearly the hospital is now in a situation of considerable change and next year will no doubt see more changes for patients and the public, particularly after this year’s main priority – C-19. It is therefore very important to listen to patients, and act on patient feedback about their experience, to help improve service design and delivery.

However, the 2019/20 Quality account does not show how the Trust has performed in the friends and family test except to say the response is in line with national averages. This is therefore less than transparent in understanding how the Trust performs in all categories. It does state it is above average for A&E and below for maternity and inpatients. The latter two are big areas of care provision and there is no narrative to identify where areas of improvement are needed or how the Trust plans to address this.

In the staff survey it is encouraging to see the improvements in scores in relation to not witnessing errors causing harm to staff or patients. However, it must be of concern that only 67% of staff would recommend Bedford Hospital; a figure that is down from a similarly low percentage recorded in the previous year. Also, of concern is the number of staff not involved in initiatives or planning, and who may plan to leave the organisation in the future.

In addition, it is unclear what the sentence means under NHS Staff Surveys that reads ‘The staff engagement score of 7.0 is average across acute trusts’.

The report tells us that only 40% of staff appraisals were completed and that only 63% of staff looked forward to going to work. These figures and the Friends and Family Test figures appear to point to significant potential issues relating to staff morale. HWCB would question whether this will lead to a rise in Patient Safety issues which is something the Trust needs to consider.

 According to the report there has been a rise in Patient Safety Issues (P54, Table 21 (Listed as Table 22)), a rise from 39.1/1000 bed days to 54/1000 bed days, and from the figures shown for the Best/Worst performing Trust, it was difficult to determine if those figures have been transposed. Also of note was that zero ‘Never Events’ (P62) were recorded which is a really good achievement, however there were six ‘Never Events’ recorded last year and HWCB would be interested to learn if any ‘Never Events’ have simply been ‘missed’ or unreported this year.

The paragraph referencing Inpatient Survey 2018 (P70 perhaps) appears to be unfinished or contains a typo and it would appear that ‘Discharge of Patients’ might still be an area for improvement.

#### Other comments

It is commendable the number of audits that the Trust has undertaken, but it is very difficult to understand the quality improvements that may have been implemented as a result, as there are no SMART improvement plans. Likewise, the Trust has many ‘Sign Up to Safety Targets’ listed in the document. However, there is no detail in the report that states the Trusts progress and achievements against these.

It is noted that in the CQUIN the trust achieved 3 standards but there was only partial achievement in 5 standards and a worrying non achievement in 2 standards, particularly the large gap in falls prevention, given that the Trust has had two deaths related to falls and a number of serious incidents relating to falls.

In addition, the SHMI data remains concerning, combined with the very poor progress of Learning from deaths reviews.

The priorities for 2020/21 are welcomed, they broadly align to the expectations set out nationally and locally, plus areas of improvement that one would wish to see for the local population. However, there are no benchmarks of current performance set and no clear targets for improvements and measurable outcomes, other than narrative statements. It would be very helpful for next year’s goals to include these benchmarks and measures. In addition, it is not clear how these goals were consulted on with patient groups and the local population and how they have been determined. Whilst they reflect some national imperatives, they do not appear to have encompassed any of the areas highlighted for improvement in the report

In relation to learning from patient complaints, HWCB would ask that the Trust include other areas where complaints might be raised e.g. using local Healthwatch.

 

‘Social Care, Health and Housing Overview and Scrutiny Committee has been reviewing quality accounts from the various hospitals used by Central Bedfordshire Council residents and intends to continue to do so.

This year the accounts have been delayed due to the COVID-19 pandemic and fall at the time when it has not been possible to consider the accounts at a meeting.  On this occasion Central Bedfordshire Council does not have a comment to add on the Account. The Committee will look to comment on the next round of Quality Accounts, subject to the deadlines imposed by the Government.’



Unfortunately the Health Overview and Scrutiny Committee’s meeting schedule does not allow for consideration of the Quality Account within the timetable, and therefore it is unable to provide a comment at this time.  All Members of the Committee have been provided with the draft for their information.

### Annex three: 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: Simon Linnett Date: 13 November 2020



Chief Executive: David Carter Date: 13 November 2020

### Annex four: external audit limited assurance report

Independent auditor’s report to the directors of Bedford hospital NHS Trust on the Quality Account

Due to COVID-19, national guidance was issued that released trust’s from securing an assurance statement from the auditors.

The trust’s auditors, KPMG, confirmed in their year end report (201/20) that ‘We are not required to provide assurance over the quality report for 2019/20. We do not have anything to report on this.’

### 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 |
| BAUS | British Association of Urology Surgeons |
| BCIR | Breast and Cosmetic Implant Registry |
| BHT | Bedford Hospital Trust |
| BLMK | Bedford Luton and Milton Keynes hospitals |
| 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 |
| CDI | Clostridium Difficile Infection |
| CMP | Case Mix Programme |
| 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) |
| GDE | Global Digital Exemplar |
| GI | Gastro-intestinal |
| GMC | General Medical Council |
| GP | General Practitioner |
| GRS | Global Rating Scale |
| GSF | Gold Standard Framework |
| 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 |
| L&D | Luton and Dunstable Hospital |
| LeDeR | Learning Disability Mortality Review Programme |
| JAG | Joint Advisory Group |
| MBBRACE | Mothers and Babies Reducing Risk through Audit and Confidential Enquiries in the UK |
| MDT | Multi-disciplinary teams – the process for clinical staff from a range of disciplines to meet and review a patient’s diagnosis and treatment plan  |
| MHRA | Medicines And Healthcare Products Regulatory Agency (MHRA) |
| MINAP | Myocardial Ischaemia National Audit Project |
| MRI | Magnetic Resonance Imaging |
| MRSA | Meticillin-Resistant Staphylococcus Aureus |
| NACEL | National Audit of Care at the End of Life |
| NACR | National Audit For Cardiac Rehabilitation |
| NAS | Neonatal Abstinence Scoring |
| NASH | National Audit Of Seizure Management |
| NBOCAP | National Bowel Cancer Audit Programme |
| NCDAH | 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 |
| OPD | Out Patients Department |
| 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 |
| PJ | Pyjama |
| 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 |
| RCP | Royal College of Physicians |

|  |  |
| --- | --- |
| RCR | Royal College of Radiology |
| RBC | Red Blood cell |
| SHMI | Summary Hospital-Level Mortality Indicator |
| SSNAP | Sentinel Stroke National Audit Programme |
| SSRI | Selective serotonin reuptake inhibitor |
| ST | Safety Thermometer |
| STT | Straight To Test |
| TARN | Trauma Audit And Research Network |
| TDA | Trust Development Authority |
| TEP | Treatment Escalation Plan |
| UNICEF | United Nations Children’s Fund |
| UTC | Urgent Treatment Centre |
| VBAC | Vaginal Birth After Caesarean |
| VTE | Venous Thromboembolism |
| WHO | World Health Organisation |
| WTE | Whole Time Equivalent |