NHS
Bedford Hospital
NHS Trust

Quality Account 2018/19

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Part one: Statement on quality from the Chief Executive

I am proud to present Bedford Hospital NHS Trust's Annual Quality Account for 2018/19.

Despite the challenges, our Trust has improved its performance significantly in many areas thanks to the dedication of our staff, volunteers and patients. We really appreciate the support of our patients, local communities and partner organisations, notably the Bedford Hospital Charity, Friends of Bedford Hospital, and Healthwatch for their unfaltering commitment to support and improve the services provided by Bedford Hospital NHS Trust.

In face of what has been another exceptionally busy year for the NHS, our staff have worked incredibly hard to provide the standards of care you expect.

Locally the needs of our population are changing and we have to adapt in order to continue to provide high quality, sustainable and modern healthcare services.

The local system faces growing challenges as the population of Bedfordshire continues to expand. The local community is one of the fastest growing in the country and with more new housing planned it is set to expand even further with a projected 20% increase by 2041. Combined with this the number of households over 65 continues to grow and Bedfordshire is expected to have one of the largest increases in the country over the next 20 years.

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.

(Insert Facts and figures about increase in attendances – cross referenced with annual report.)

Even with this increase in demand, considerable improvements in the quality of care the Trust provided were achieved. These were reported through our Quality Reports and included the following headline improvements:

- Ranked in the top 2% in the NHS for both catering and cleanliness in the PLACE assessment.
- Took part in the national End PJ Paralysis campaign getting our patients dressed and out of bed to help prevent longer than necessary hospital stays and avoid the associated problems.
- Installed a new £1m MRI Scanner - generously funded by the Bedford Hospitals Charity - that has made significant improvements to the service we offer for both patients and staff.
- Achieved consistently low infection rates, passing two years since the last hospital-apportioned MRSA bacteraemia case.
- Opened a new Urgent Treatment Centre (UTC) opened in October that has helped alleviate some of the consistent pressures felt within our A&E Department.
- Focus on reducing medical outliers on surgical wards and minimising patient moves by a ward reconfiguration to rebalance the medical to surgical beds with significant improvement for patients and staff
- Renewed Endoscopy Department JAG accreditation without any complications or caveats, thanks to the Endoscopy team.

- Our maternity team significantly reduced category 4 tears
- Invested £900,000 in a new and improved Cardiac Catheter Suite with a new high specification camera that produces higher quality images and reduces the amount of radiation passed to patients during treatment

The CQC inspection in September 2018 recognised the strides we have taken towards improving quality, not only in 2018/19 but in the preceding years and these have been reflected in the CQC inspection report that was published in December 2018. BHT is rated as GOOD for being caring and responsive.

The CQC reports show that 80% of the 39 potential ratings were GOOD (up from 66% in the last inspection). Although our overall rating has not changed ('Requires Improvement'), we have substantial areas of excellent practice including in Children and Young People; Surgery and Outpatients which all have had their overall rating improved to 'Good'.

CQC inspection covered two new areas, 'well-led' and 'use of resources'. The Trust was rated as 'Good' under 'well-led' which means that the leadership, management and governance of the organisation assure the delivery of high quality person-centred care, support learning and innovation, and promote an open and fair culture. This is the new strict assessment criteria introduced by the CQC within the last 12 months and is a significant achievement showing our commitment to providing the best possible outcomes for our patients.

We were rated 'Requires Improvement' under 'use of resources' as we continue to work towards a sustainable future within the BLMK Integrated Care System.

We are not complacent and know there are areas that still require some work. The CQC report is extremely constructive and will help guide us towards some more immediate developments.

Overall, we feel proud of these ratings and it is great to hear that the improvements we have made as a hospital have been recognised by our regulators. We are now determined to build on these improvements, implement all of the CQC's actions and further improve the service we provide to patients.

One way we can ensure the continuous improvement of our services is by furthering our commitment to ensure we listen to our patients, carers, visitors and staff. This year we have held a series of constructive patient listening events to hear about real experiences, find out what we do well and areas for improvement where we have let patients down. Looking forward, we will design our services around patients, using patient feedback to inform our priorities and focus on the areas that mean most to you within our quality improvement strategy.

On behalf of the Board, I would like to say thank you to all of our staff and volunteers for their ongoing commitment to providing high quality, compassionate care and for continuing to strive to make improvements that enhance the quality of our patient care. And thank you to our patients for helping us to make our services the best they can be for everyone.

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

Stephen Conroy
Chief Executive
Bedford Hospital NHS 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 2018/19 is included in this account alongside our priorities and goals for quality improvement in 2019/20 and how we intend to achieve them.

Part two: Review of 2018/19 quality improvement priorities

This section reviews the Trust's actions and performance against its 2018/19 quality improvement priorities.

Following consultation with staff, stakeholders and patient organisations, the Trust identified three key quality priorities for 2018/19.

2.0 Priority 1: Patient safety

Aim: To reduce the number of inpatients who fall by 5%:

This target has not been achieved. One of the major reasons behind this is that in 2018/19 the hospital treated more patients than ever before. Due to this increase it is difficult to measure the 5% drop, as with a higher amount of patients the threshold increases.

Despite not hitting the initial target the Trust's total falls per 1000 occupied bed days remains below the national average of 6.63 at 5.3 (accumulative as at February 2019). This is a more measurable objective

The table below shows the number of falls per 1000 occupied bed days by month for 2018/19 and falls with harm

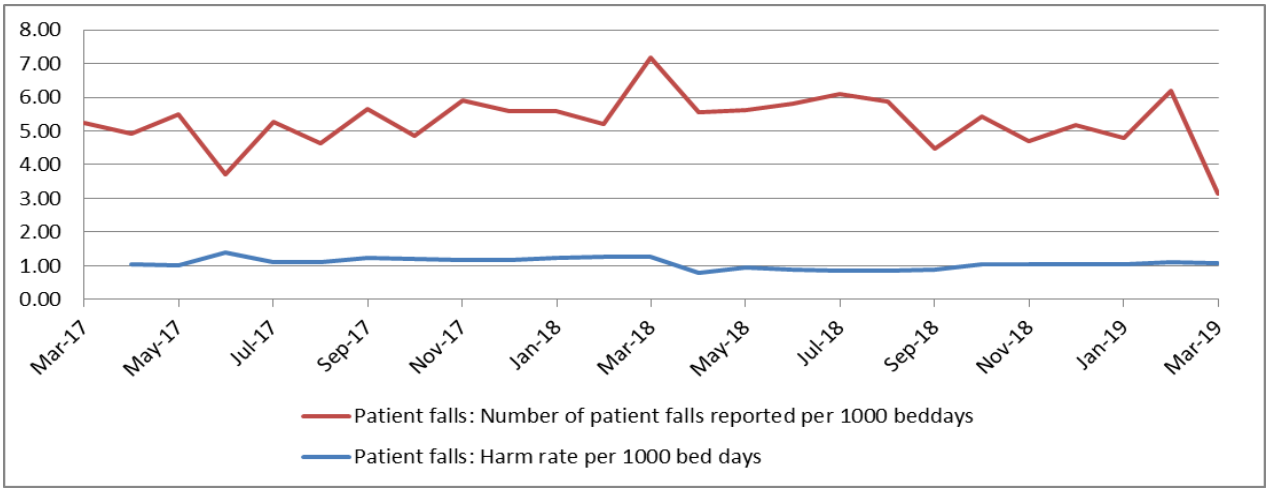


Table 1: Falls per 1000 bed days 2018/19

Quality improvement initiatives

- Introduction of a rapid a multidisciplinary assessment post fall (SWARM), for any moderate and severe harm fall. The SWARM was introduced in May 2018 following each fall with harm identified immediate actions needed.
- The Swarm concept is now completed for all patients that have more than one fall.
- A falls prevention workbook has been produced to enhance learning opportunities and share learning.
- A bi-monthly falls communication bulletin has been established and will publish results of the 'focus on falls' program.
- The '*Focus on Falls'* initiative and training programme commenced in May 2018. Two wards with high risk patients are identified bi-monthly to participate. A four week program focused on elements of NICE CG161 guidelines: Falls in older people: assessing risk and prevention:

    - Week 1 - Falls leaflets and placemats given to all patients over 65 years old
    - Week 2 - All patients over 65 years have recorded lying and standing BP staff are trained on the importance of both measurements of BP
    - Week 3 - All patients who are at risk of falls have a medication review - New documentation distributed
    - Week 4 - Intentional Rounding (regular checks on patient's needs) at night, peak times when patients fall
    - Posters are displayed to increase awareness for patients, staff and visitors.
    - Daily quality rounds are conducted to identify any issues at point of care by falls lead, ward manager or ward champion.
    - Education sessions are provided on falls prevention
    - Introduction of mobility status posters displayed at patient's bedside to inform all of mobility, examples below;

Improved practice

- Improved time of x-ray ordering and subsequent review of X-rays
- Improved time of pain relief medication
- Improved documentation within patient records, incident report and investigations
- Swarm information is shared at falls steering group, within the Matrons monthly falls report and Champions to disseminate learning
- Feedback from staff;

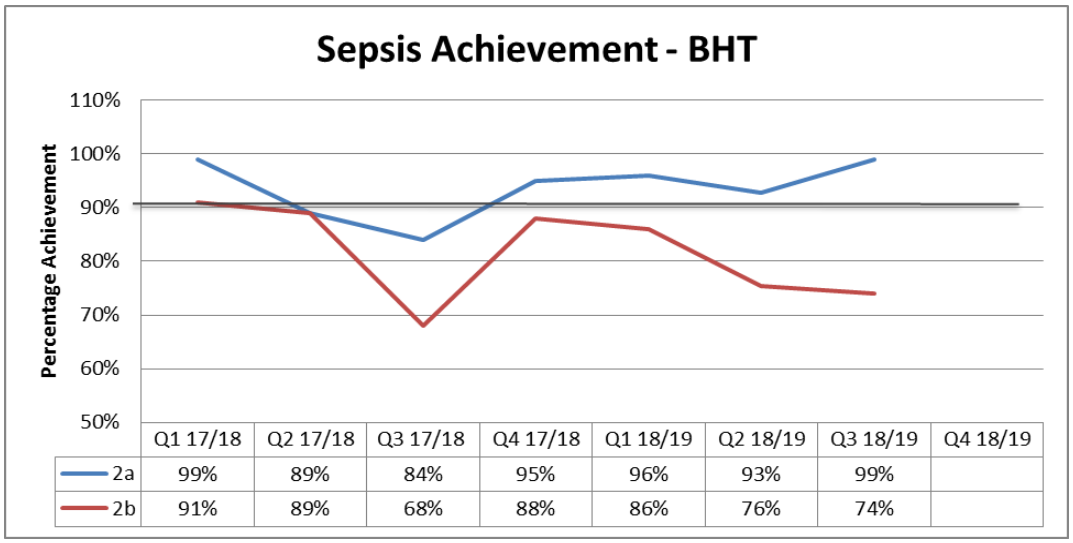
    - Awareness has been raised regarding falls prevention strategies.
    - Mobility status posters very useful to identify at risk patients.
    - Increased awareness on medication reviews relating to falls and completing lying/standing blood pressures effectively.

Priority 2: Clinical effectiveness priorities

Improve the diagnosis and treatment of sepsis by:

- The timely identification of sepsis in A&E and acute inpatient settings is essential to early treatment of sepsis. This involves ensuring that patients with symptoms of sepsis are assessed in a timely manner to ensure treatment is started in line with their symptoms.
- The timely treatment for sepsis in A&E and acute inpatient settings is therefore enabled by early recognition and diagnosis; using the sepsis six pathway patients who are classes as ‘red flag’ should receive antibiotics within one hour of diagnosis.

The graph below shows progress over the year, 2a relates to early identification of sepsis which was achieved. 2b relates to timely treatment which requires further focus.



	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19
2a	99%	89%	84%	95%	96%	93%	99%	
2b	91%	89%	68%	88%	86%	76%	74%	

Table 2: Sepsis Achievement

Quality improvement initiatives

- All oncology patients are given a prescription for antibiotics to reduce the time to antibiotics in A&E, when they present at A&E with symptoms of sepsis antibiotics are given within one hour.
- Sepsis awareness week was held in September with a number of “activities” to raise awareness of sepsis to both clinical staff and patients.
- A local audit was in December recommended a review the sepsis toolkit.
- The patient information leaflets are in all clinical areas
- Good practice identified during sepsis audits have been highlighted with a sepsis certificate

Training

- Sepsis training is included in all resuscitation training
- ED training sessions focus on learning from incidents.

Improved practice

- The sepsis working group is driving improvements and upwardly reports through the Patient Safety Group.
- Over the past 12 months identification of sepsis has improved and the CQUIN achieved.

Priority 3: Patient experience priority

Improve the experience of patients and their family at the end of their life by implementing; “The Gold Standards Framework for End of Life Care”

Background

The Gold Standards Framework (GSF) is a systematic evidence based approach to optimising care for people in the last year of life with any condition in any setting. GSF focuses on enabling

generalists in community and hospital settings to work more effectively with specialists, to care for patients from early identification, right through to discharge home or care in the final days.

The Hospital Charities funded the two year project, which commenced in March 2018, in two clinical areas, Harper and Pilgrim wards.

The expected outcomes from implementing the GSF;

- Increased proportion of patients dying in their preferred place
- Earlier identification of hospital patients thought to be in the last year of life
- Increased patients offered advance care planning discussions about preferences
- Reduced hospital deaths, hospital bed days and crisis admissions
- Increased confidence in staff.

The table (3) below identifies key actions taken in year one. Since March 2018 ward staff have completed training and the baseline data collection, including deaths/discharges and staff confidence questionnaires. Program outcomes for patients will be measured in 2020 and monitored through the End of Life Care Steering Group.

GSF working group includes matrons, ward managers and palliative care team representatives.

Targeted training has been delivered to medical and nursing staff in the GSF clinical areas and sessions have been delivered to wider medical and nursing forums.

Progress	
March - May 2018	National workshop attendance Baseline data Collection Ward based education Ward information boards
June – August 2018	National workshop attendance Ward based education Medical education sessions including Proactive indicator Guidance (PIG)
September – November 2018	National workshop attendance Publicity via communications team GSF log in each clinical area ACP and Discharge prompt

Table 3

2.1 Quality improvement priorities for 2019/20

This section sets out the Trust's quality improvement priorities for 2019/20. It details our planned improvements for each priority, how we will report and measure our progress and sets out our measures of success.

The vision for the organisation remains providing high quality, sustainable services for the people of Bedfordshire. The trust continues to invest in identifying and developing leaders to deliver this vision and the trust corporate objectives for the benefit of patients and staff.

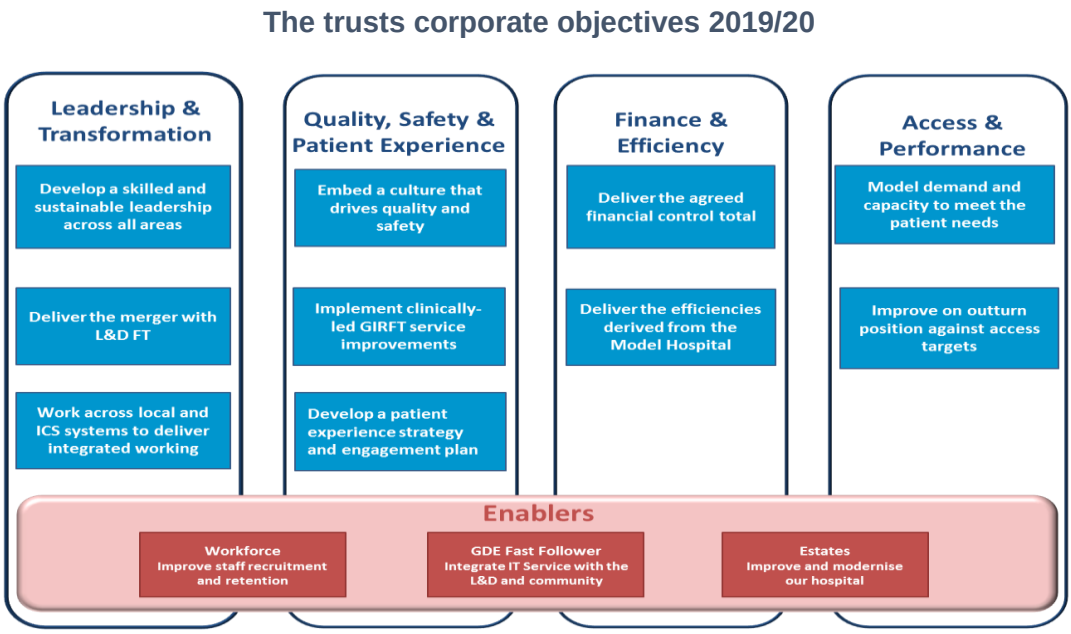


Figure 1: Trust Corporate Objectives 2019/20

Quality priorities 2019/20

To determine the trusts quality improvement priorities for 2019/20 a short list was established by reviewing incidents, complaints, concerns and serious incidents, the table below is the shortlist, with the red incidents the chosen priorities;

Patient Experience	Patient Safety	Clinical Outcomes
Patient participation and engagement	Theatre safety	Theatre safety
Communication and understanding	Reduce harms by 5% PU + falls	Mental health pathway Developing frailty pathways
Quality of letters and TTO	Reduce number of still births	**Speeding up diagnosis – cancer**
Discharge planning	**Documentation – quality of notes**	

Following consultation with the patient council, volunteers, staff, students, Healthwatch and the CCG the following priorities were identified.

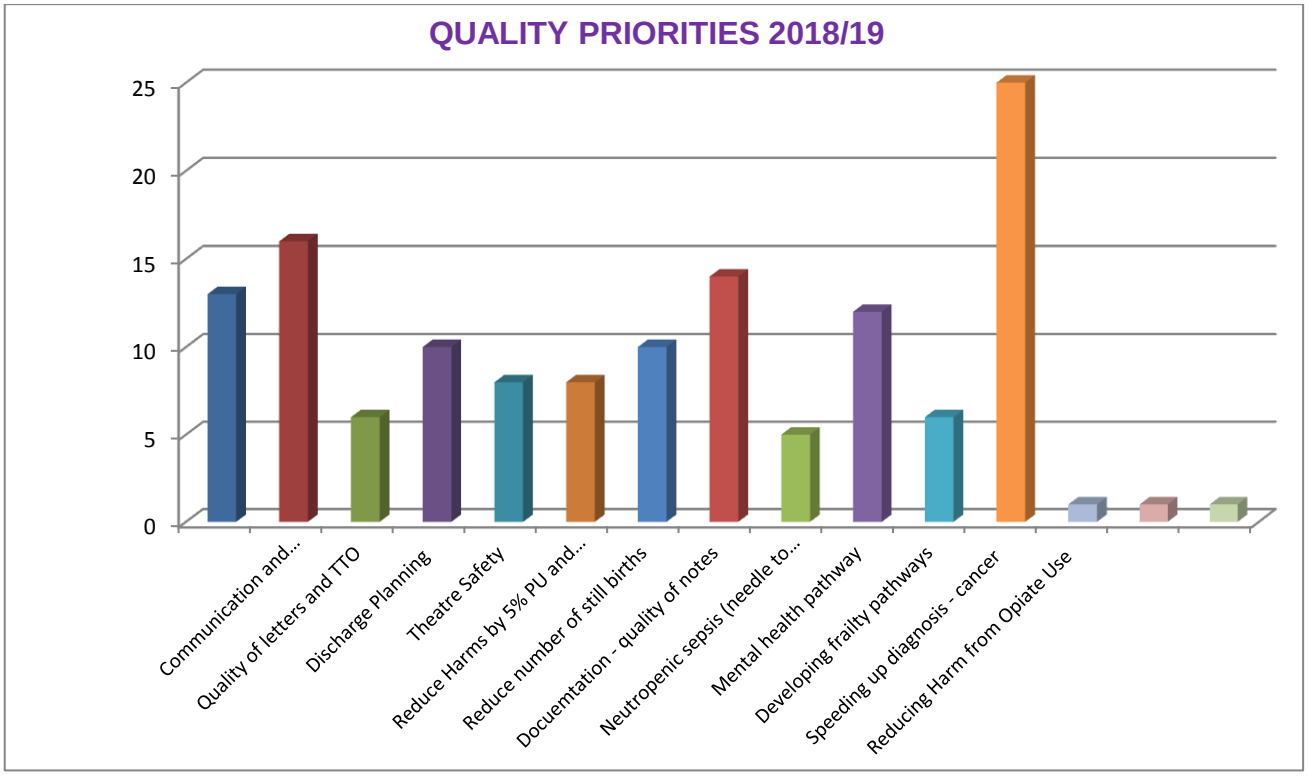


Table 3: Quality Priorities 2018/19

These priorities will be integrated within the quality strategy which is being developed. Detailed over the page is how we will deliver these priorities.

Priority 1 2019/20: Patient safety

Improve patient documentation and the quality and access to their notes by implementing the following;

- Investing around £10m in upgrading our IT infrastructure as part of the Global Digital Exemplar (GDE) Fast Follower Programme, delivering considerable change over the next 3 years including:
    - Digitisation of paper patient records through an on-site scan centre and implementation of an electronic document record management system (EDRMS).
    - 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.
    - 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 launch of a digital communications platform within the trust enabling video calls, instant messaging, file sharing and improved communication with other organisations.
- Implementation of a new ED 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).
- Improved Nursing documentation role out April 2019

Priority 2 2019/20: Clinical outcomes

Speeding up diagnosis of cancer by implementing the following;

- Increasing clinical nurse specialist in colorectal speciality to implement the straight to test pathway (STT)
- Pilot for suspected lung cancer patients to access CT and OPD on the same day
- Gynaecology patients to have ultrasound scan before OPD
- Continue with Breast one stop clinic
- Review all cancer specialities to reduce waiting for diagnostics

Priority 3 2019/20: Patient experience priorities

To improve communication and understanding patients have about their care and treatment by implementing the following;

- Reviewing all patient appointment letters to ensure that they are clear and understandable to our patients
- Hold more patient experience and listening events to fully understand the patient experience and learn where we can make improvements
- Provide Patient leaflets and information in the top three local languages, large print and braille so more patients can have access to these.
- A new and improved website that will make it easier for patients to access important information related to their healthcare.

2.2 Priority clinical standards for seven day working

The trust has engaged with NHS Improvement in moving towards the new board assurance framework which is due full implementation from March 2019. The trust has submitted data using the pilot template based on the spring 2018 data return which was supplemented by local re-audits in medicine, surgery and paediatrics for Clinical Standard 2.

This was tabled at trust board February 2019. In terms of Clinical Standard 2 (time to consultant review) the trust has made progress in acute medicine achieving 79% weekdays and 95% weekends.

Further work is underway in other specialties. For Clinical Standard 5 (access to diagnostics) the trust has made progress with MRI now available 12 hours daily 7 days per week. Echo and ultrasound 24 hours is not achievable within current resource.

Clinical Standard 6 (consultant-directed interventions) remains a challenge for interventional radiology and the trust is continuing to explore a networked solution. Otherwise the standard is delivered.

Clinical Standard 8 (daily/ twice daily consultant review) is not achievable within current resource and is a major driver for a merger solution.

2.3 Participation in national clinical audits

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

During 2018/19, national clinical audits covered relevant health services that Bedford Hospital NHS Trust provides. During 2018/19 Bedford Hospital NHS Trust participated in 100% (63/63) of NHS England Quality Accounts national audits together with the JAG (Joint Advisory Group on GI Endoscopy) Accreditation Programme for Endoscopy

The national clinical audits in which Bedford Hospital NHS Trust was eligible to participate, and for which data collection was completed during 2018/19

Bedford Hospital NHS Trust participation in national clinical audits	Percentage participation /Continuous
BAUS (British Association of Urology Surgeons) Urology Audit: Female Stress	Continuous

Urinary Incontinence Audit	
BAUS Urology Audit: Nephrectomy Audit	Continuous
BAUS Urology Audit: Percutaneous Nephrolithotomy	Continuous
Breast and Cosmetic Implant Registry (BCIR)	Continuous
Case Mix Programme (CMP)	Continuous
Elective Surgery (National PROMS Programme)	Continuous
Falls and Fragility Fractures Audit Programme (RCP) Fracture Liaison Database Inpatient Falls National Hip Fracture Database	Continuous Continuous Continuous
Feverish Children (Care in the Emergency Department) (RCEM)	Completed
Head and Neck Cancer Audit	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 Enquiries	Continuous
Maternal, Newborn & Infant Clinical Outcome Review Programme (MBBRACE) – Maternal Mortality Surveillance and Mortality Confidential Enquiries	Continuous
Maternal, Newborn & Infant Clinical Outcome Review Programme (MBBRACE) – Perinatal Mortality and Morbidity Surveillance	Continuous
Maternal, Newborn & Infant Clinical Outcome Review Programme (MBBRACE) – Perinatal Mortality Surveillance	Continuous
Medical and Surgical Clinical Outcome Review Programme: Acute Bowel Obstruction - NCEOPD	Continuous
Medical and Surgical Clinical Outcome Review Programme: Pulmonary Embolism - NCEOPD	Continuous
Myocardial Ischaemia National Audit Project (MINAP)	Continuous

National Adult Community Acquired Pneumonia (BTS)	In Progress
National Adult Non-Invasive Ventilation (NIV) (BTS)	In Progress
National Asthma and COPD Audit Programme - Adult Asthma	Continuous
National Asthma and COPD Audit Programme - Chronic Obstructive Pulmonary Disease (COPD)	Continuous
National Asthma and COPD Audit Programme – Pulmonary Rehab	Continuous
National Audit for Rheumatoid and Early Inflammatory Arthritis (NCAREIA)	In progress
National Audit of Anxiety and Depression	Completed
National Audit of Breast Cancer in Older Patients (NABCOP)	Continuous
National Audit of Cardiac Rhythm Management (NICOR)	Continuous
National Audit of Cardiac Rehabilitation (University of York)	Continuous
National Audit of Care at End of Life (NACEL)	Completed
National Audit of Dementia Audit (RCP) incorporating Spotlight Audit: Assessment of Delirium in Hospitals	Completed
National Audit of Percutaneous Coronary Interventions – PCI (NICOR)	Continuous
National Audit of Seizures and Epilepsies in Children and Young People (RCPCH)	In Progress
National Bowel Cancer Audit (NBOCA)	Continuous
National Cardiac Arrest Audit (ICNARC))	Continuous
National Comparative Audit of Blood Transfusion Programme: Management of Massive Haemorrhage Use of Fresh Frozen Plasma and Cryoprecipitate in Neonates and Children	In progress Completed
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	Continuous Continuous Completed Completed Continuous
National Emergency Laparotomy Audit	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 Mortality Case Record Review Programme	Continuous
National Oesophago-Gastric Cancer Audit (NAOGC)	Continuous
National Neonatal Audit Programme (NNAP)	Continuous
National Paediatric Diabetes Audit (RCPCH)	Continuous
National Prostate Cancer Audit (Royal College of Surgeons)	Continuous
National Vascular Registry (Royal College of Surgeons)	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 (SHOT)	Continuous
Surgical Site Infection Surveillance Service (Public Health England)	Continuous
Vital Signs in Adults (Care in the Emergency Department) (RCEM)	Completed
VTE Risk in Lower Limb Immobilisation (Care in the Emergency Department) (RCEM)	Completed

Table 4: National clinical audits in which Bedford Hospital NHS Trust was eligible to participate (NHS England Quality Account and JAG Accreditation

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

National clinical audit reports

National Audit	Actions
National COPD Audit Programme – COPD: Working Together Clinical Audit Report and COPD: Time To Integrate Care Organisational Audit Report 2018	• A full time respiratory physiologist has been appointed • Respiratory nurses have completed a 2 day ARTP (Association for Respiratory Technology & Physiology) training programme to assist with delivering quality assured diagnostic spirometry • Respiratory physiologist is investigating the feasibility of spirometry reports being made available electronically • Lead respiratory specialist nurse is a member of the smoking cessation steering group who are involved with working towards achieving the CQUIN 2018 “Risky behaviour” • Discharge bundles in place to promote/assist with identifying and if accepted, offering support to current smokers with prescribed

National Audit	Actions
	smoking cessation pharmacotherapy • 7 day cross sector COPD service is in place, review with BCCG extending the service to cover bank holidays to ensure specialist review and support
National COPD Audit Programme : Pulmonary Rehabilitation: An Exercise in Improvement 2018	• Bedford pulmonary rehab team (PR) to trial changing to ISWT (Incremental Shuttle Walking Test) • Lead for PR to research suitable muscle strength assessments to assist with a more detailed and accurate prescribing of exercise training • Changes to be made to current exercise sheets to incorporate increased goals activity to continue post course and discussed at post assessment • To look into obtaining spirometry readings from the previous year from referrals and GPs to assist with managing patients at high risk of exacerbation and hospital admissions • Team to continue to promote smoking cessation and vaccination, inhaler technique and check on most suitable medications with respiratory team • To continue to be involved with Breathe Easy and IPF support group. To attend CCG events and respiratory training days to promote the service • To support eligible patients to complete PR programmes where possible by the adding of additional information about the programmes and have patients sign off on the talks they have attended
Learning Disabilities Mortality Review 2018	• Findings discussed and actioned at: ○ CCG meeting ○ Learning from Deaths meeting ○ Safeguarding Board
Royal College of Emergency Medicine (RCEM) Fracture Neck of Femur 2017/18	• Department (ED) Registrar/FY1/FY2 teaching sessions • Nursing team leader to ensure patient's pain score is evaluated on receiving the patient at the majors desk to meet the 15 minute national target and to immediately request a pain relief prescription and x-ray from the ED physician and evaluate • Reinforce importance of clear documentation in notes at nursing and registrar teaching sessions
RCEM Pain in Children (Moderate and Severe Pain) 2017/18	• All children to be streamed/triaged within 15 minutes of arrival • On arrival pain assessment evaluation will be undertaken by the streaming doctor for children who present with injuries and by the paediatric/triage nurse for those children who are non-traumatic (Pain score in adolescent population is 0-10) • Nurse/doctor administering the analgesia to handover/visual aid on Extra Med to evaluate the child for pain 60 minutes post analgesia • Reinforce importance of timely pain assessment evaluation and administration of analgesia in children at teaching sessions and on the "shop floor", local re-audit
RCEM Procedural Sedation in Adults 2017/18	• Department (ED) Registrar/FY1/FY2 teaching sessions • To add oxygen therapy as a compulsory field on the procedural sedation form to ensure appropriate oxygen therapy is given from the start of the procedure until return to baseline
National Diabetes Inpatient Audit 2017 (NHS Digital)	• QI commission hypoglycaemia project being undertaken • Installation of a web linked blood glucometer • Bedtime snack for all patients on insulin • Development of link nurses for each ward to improve the number of nurses available for training

National Audit	Actions
	• To promote insulin self-administration as per local guidelines • Insulin e-learning module to be developed for mandatory training
Trauma Audit and Research Network (TARN) 2018	• Regular meetings to discuss findings from quarterly reports and review cases/practice
National Hip Fracture Database (NHFD) Annual Report 2018	• Discussed at NOF (Neck of Femur) team meeting comprising consultants from Care of the Older Person, Trauma & Orthopaedics, Anaesthetics and the trust's Trauma Co-ordinator • Regular monitoring of the NOF situation to achieve BPT (Best Practice Tariff)
National Audit of Breast Cancer in Older Patients (NABCOP) (The Royal College of Surgeons of England) (Annual Report 2018)	• Discussed at Breast MDT • To be discussed at April 2019 Cancer Services Peer Review Operational meeting • Bedford is performing above national average and MDT to sustain current practice
National Oesophago-Gastric Cancer Audit (Annual Report 2018)	• Presented Quality Board • To be discussed at April 2019 Cancer Services Peer Review Operational meeting • Trust initially identified as an outlier for CT staging. This was investigated and found due to incomplete documentation being submitted. Issue resolved
Assessment of Delirium in Hospital for People with Dementia - Spotlight Audit 2017-18	• Discussed at Dementia Focus Group and Safeguarding Board • Current delirium tool has been reviewed and amended • Tool is incorporated into 'new' admission pack for all hospital emergency admissions - this is out for printing • Trust wide changing to ICE system for the production of discharge letters - incorporating the detail about assessment and results into the template • Care plan review • Training plan currently in place and reviewed against Skills for Health Guidance
National Emergency Laparotomy Audit 2018	• Discussed at Anaesthetics audit meetings • Local audit undertaken • NELA priority category to be accurately documented and updated as necessary from information given by the senior surgical team member
National Prostate Cancer Audit (NPCA) Annual Report 2018	Consultant lead for audit confirmed that the following national recommendations from the report are already in place at Bedford Hospital: • The use of pre-biopsy multiparametric MRI has been increased and its use avoided post biopsy • The use of transperineal prostate biopsy has been increased where necessary to reduce the risk of post-biopsy sepsis and to maximise diagnostic accuracy and risk stratification • There is active surveillance in the first instance for men with low risk prostate cancer • Reasons why men with locally advanced disease are not considered for radical local treatment are always investigated • Data on side effect prevalence from the report is used to ensure appropriate counselling and management for all patients • If any outlying performance is confirmed, engagement with all partners will take place including the NPCA, to review practice

National Audit	Actions
	urgently and instigate quality improvement measures • Engagement with the NPCA Quality Improvement initiatives planned for 2019 • Ongoing review and improvement of data completeness focussing particularly on performance status, use of multi-parametric MRI and biopsy route
Intensive Care National Audit and Research Centre (ICNARC) - Case Mix Programme (2017 – 18)	• Results reviewed and actioned at Critical Care team meetings
National Bowel Cancer Audit (Annual Report 2018)	• Findings shared with all MDT members • To be discussed at April 2019 Cancer Services Peer Review Operational meeting • Results re-checked and found to be correct • To ensure that Hartmans procedures are recorded as low anterior section or TME (Total Mesorectal Excision)
National Vascular Registry (Royal College of Surgeons of England) (Annual Report 2018)	• Reports are discussed and actioned at vascular meetings
National Neonatal Audit Programme 2017	• Discussed at the May 2018 Paediatric audit meeting • Engagement with maternity has shown an improvement in the number of mothers who receive AN steroids • Staff training has taken place to improve the achieving of babies' temperature within range • Audit has taken place reviewing babies' temperatures pre admission to the neonatal unit and ensuring every baby has a hat on post delivery • Perinatal meeting and maternity newsletter have raised awareness of mothers who are given MgSO4 • Targeted tidal volume ventilation has been introduced re Bronchopulmonary dysplasia • Ensure ROP (Retinopathy of prematurity) screening is carried out pre-discharge regardless of gestational age • Mother's milk at discharge: • East of England (EOE) Necrotising enterocolitis (NEC) care bundle continues to be promoted on the Neonatal Nursing dashboard • Baby Friendly initiative encouraged • Physiotherapy lead for NNU carries out clinical developmental checks at 2 years of age and details forwarded to NNU consultants for update of records
BTS Paediatric Pneumonia Report November 2016 – January 2017	• Discussed at the May 2018 Paediatric audit meeting • Local paediatric pneumonia guideline in development • Local guideline for the use of humidified high flow oxygen in children with pneumonia being developed

National Audit	Actions
The National Clinical Audit of Seizures and Epilepsies for Children and Young People	•

National Paediatric Diabetes Audit 2016/17	• To investigate and action:
	  ○ Why some patients are not receiving a Health check
	  ○ Annual HbA1c is not always undertaken
	  ○ Reasons for hospital admission
	• Better clinic experience for patients due to greater patient engagement
	• Now working in DM QI collaborative with RCPCH
	• July report findings presented at 6th September Paediatric audit meeting
	• Training of outpatient staff to ensure BP measurement is undertaken accurately and an annual check is undertaken if BP>91st centile
	• Manual BP equipment available in Outpatients
	• To improve the rate of children receiving HbA1c measurements annually the Paediatric Diabetes administrator will monitor patients who miss appointments and inform the team
	• Review the contacts made to the "Out of hours" service over a 3 month period to understand why there is a high percentage of children with diabetes being admitted
	• To undertake an audit of patients admitted with diabetes
	• Training for junior doctors on discharge letters to ensure that the admission is coded appropriately regarding primary reason for admission
	• Discussion with Diabetes Clinical Psychologist regarding the undertaking of a Wellbeing questionnaire to ensure patients are screened for psychological co-morbidities i.e. eating disorders, anxiety

National Diabetes Transition Audit 2011-2017	• Discussed at the January 2019 Paediatric audit meeting • Findings to be discussed with the adult diabetes team
Regional audit East of England Cancer Alliance: Neutropenic Sepsis Audit 2018	• Discussed at East of England Cancer Alliance meeting 10 July 2018 and at Oncology Business meeting 7 September 2018 • Acute Oncology Service (AOS) are team members of the Sepsis Steering Group which is promoting increased awareness of sepsis, including neutropenic sepsis, to all staff • Meeting with GP Liaison Service has resulted in the AOS being alerted to chemo patients with temperatures being advised to attend A&E. This has enabled the AOS to inform A&E of the patient's arrival to facilitate timely antibiotic prescribing and for AOS, where possible, being able to attend A&E to assist with the antibiotic administration if needed • A neutropenic sepsis antibiotic prescription card has been implemented. The card has a signed prescription by the oncologists for the appropriate antibiotic depending on the patient's allergies and is given to patients prior to commencing chemotherapy. If patient attends A&E with suspected neutropenic sepsis the pre-signed prescription enables the triaging nurse to facilitate

National Audit	Actions
	immediate antibiotic administration
National Survey Report 2018 RCPCH (Royal College of Paediatrics and Child Health): Facing the Future	• Discussed at January 2019 Paediatric audit meeting • Discussions ongoing to meet recommended RCPCH standard "A paediatric consultant is present in the hospital during times of peak activity"

Table 5: National clinical audit reports received during 2018/19 with planned action (includes a regional audit and a national survey)

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.

2.4 Bedford Hospital NHS Trust local audits

The reports of 47 local clinical audits were reviewed by Bedford Hospital NHS Trust in 2018/19 and the Trust intends to take the following actions to improve the quality of healthcare provided, audit results and recommendations presented at the appropriate audit meetings, other actions are listed below:

Local clinical audits and associated actions:

Local clinical audit	Month presented	Actions
Clinical Effectiveness		
Integrated Medicine		
Weekend Handover Audit	May 2018	• A new handover template has been created • Plans are underway to develop an online form by May 2019 to facilitate multiple people being able to access the document simultaneously and from different locations within the hospital • Email communication, information sheet and teaching session to be arranged on weekend handover requirements • Re-audit to be undertaken to assess compliance with the revised handover documentation

Triage in the Emergency Department	May 2018	• Training arranged for A&E staff regarding triage to include:
		  ○ Improving waiting times in line with triage categories
		  ○ Promoting of completion of triage categories
		• Re-audit

Re-audit Ambulatory Emergency Care Unit (AECU)	May 2018	• New guideline on the service will be based on RCP recommendations • Referral criteria to be updated • Re-audit
Putting Feet First – Diabetic Foot Assessment	May 2018	• MDfT now in place to raise awareness of diabetes related foot problems in hospital • Lead Podiatrist, DCNS and TVN to lead education campaign on the wards for the assessment tool • Re-audit
Smoking History Documentation in Acute Medical Take Patients (QI	September 2018	• Findings discussed at quarterly Smoking Cessation Group • Findings discussed at monthly CQUIN meeting • Documentation of a smoking cessation history assessment now recorded on Extramed

Local clinical audit	Month presented	Actions
topic)		• Staff training undertaken on all adult wards excluding Maternity to undertake assessment • Posters promoting smoking status documentation and referral (to smoking cessation services/ward smoking cessation champions) displayed in ED and AAU • Smoking champions on every adult ward excluding Maternity • Re-audit 2019/20
M&M Associated with Performing Bone Marrow Aspiration & Biopsy	September 2018	• No major adverse outcomes (haemorrhage or permanent nerve damage) during the audited time period • To continue with current standard practice and re-audit 2020
Brain MRI Reporting Standards in Patients with Cognitive Impairment	September 2018	• Good compliance with EFNS (European Federation of Neurological Sciences) and NICE guidelines: Standards of reporting Brain MRI in patients being assessed for Dementia • Protocols to continue to be consistently scored to allow for compliance and uniformity in reporting
Compliance with BTS (British Thoracic Society) Guidelines for the Follow Up of Indeterminate Pulmonary nodules	September 2018	• BTS/Cancer Research app to be downloaded by reporting radiologists which has the flowchart of BTS guidelines built in • Reporting template to be available using Voice recognition software • Guidelines to be re-circulated to serve as a reminder
Audit of Mammography Reporting Against Royal College of Radiology (RCR) Standards in Bedford Hospital	November 2018	• Staff made aware of the guidance from the British society of Breast Radiology on use of the 5 point mammography scoring system and the expected updated guidance on breast density reporting • Re-audit once updated guidance published
VTE Prophylaxis Prescription Following Positive Risk Assessment	March 2018	• All doctors receive training at induction on VTE • Ongoing VTE teaching focuses on and demonstrates the correct usage of the VTE assessment tool • Doctors' assessments and prescribing is overseen by the VTE co-ordinator and pharmacy teams • Training provided to juniors on learning from HAT investigations
Acute Kidney Injury (AKI) Audit	November 2018	• Introduction of an AKI management sticker in accordance with NICE guidance • Staff training to be undertaken • To investigate whether red flags can be used for reporting on ICE • Re-audit
Oxygen Prescribing Re-Audit	January 2019	• Regular teaching sessions arranged for medical and nursing staff at ward level • Ongoing liaison with Pharmacy to review whether there are any further software fields that can be adapted to encourage oxygen prescription • Re-audit 2019/20
Head and C-Spine Injury Audit (CT Head QI topic)	24 January 2019	• Annual training for junior doctors and nurses on the recommendations set out in the NICE CT guidelines • Poster displaying NICE CT guidance to be displayed in ED clinical areas
Adherence to British Thyroid	January 2019	• Re-education of staff on the reporting standards of the Ultrasound U-Classification of thyroid nodules

Local clinical audit	Month presented	Actions
Association Ultrasound U-Classification of Thyroid Nodules Reports		
Sepsis Audit	January 2019	• Continuing education to all clinical staff through mandatory training • Focus of training to change to increase ward/department based scenario training from 2020 • Sepsis Awareness week scheduled • To review screening tool once results of RCEM Feverish Child audit are published • New Sepsis lead for the trust in post • Re-audit but focus will change to “sick” patients i.e. those that need a higher level of care and include a separate paediatric component
Diabetes Foot Assessment Audit	March 2019	• Diabetic adult foot assessment document to be added to the quality round • Foot assessment tool to be simplified and added to the nursing care plan and included in the admission pack • During a one week period matrons will be reminded daily at the quality meeting re diabetic foot assessments • Training on undertaking the assessment will be rolled out to all ward staff targeting those wards with poor compliance first • To develop leaflets for inpatients with advice on foot care • To investigate developing a diabetes care competency forward staff • Re-audit
Planned Care		
NELA (National Emergency Laparotomy Audit) Theatre List delays –based upon action from national findings	May 2018	• Documentation recorded on OPERA regarding causes of any delays to be improved and requirement reinforced by theatre management team • NELA priority category to be accurately documented and updated as necessary from information given by the senior surgical team member • Reduce the delays in patients going to theatre by filtering patient entry by stated clinical priority
Decision to Admission Times to Critical Care Complex Re-audit	July 2018	• Mandatory field on Metavision for capture of reason for any delay in admission of patients to ICU within one hour of decision to admit • Any reasons for delay to be reviewed and relevant cases to be presented in departmental M&M meetings • Re-audit 2019/20

Surgical Management of Distal Radial Fractures in Adults	September 2018	• Agreed with A&E consultants to ensure referral of every case of fracture distal radius to orthopaedics if:
		  ○ Intra-articular extension
		  ○ Manipulation was done

Partial Nephrectomy Outcomes in the Management of Renal Cancer	November 2018	• To undertake a prospective audit to compare local findings with national data
Colorectal Cancer	November	• To discuss at Colorectal MDT :

Local clinical audit	Month presented	Actions
Pathway	2018	○ the appointing of two triage colorectal nurses to liaise with the colorectal consultants to facilitate patients taken straight for tests as per NICE guidance instead of being seen in clinic first ○ having direct referrals from Endoscopist to radiologist
Pain Buster Audit	November 2018	• Findings fed back to ward link nurses 24 October 2018 • Ongoing daily pain team review of pain buster observation charts during treatment • Annual update and training to surgical ward staff of pain buster observations and removal documentation • Prescription protocol for Metavision actioned • Ongoing annual audit monitoring multidisciplinary compliance
The Role of Pre-clinic MRI in 28 Day Prostate Cancer Diagnostic Pathway	November 2018	• Implementation of pre-clinic MRI for all patients referred for suspected prostate cancer to achieve the 28 day target
Use of Bone Scans in Patients with Prostate Cancer Gleason 3+4 and PSA <10	January 2019	• To consider omitting bone scan in intermediate risk prostate cancer, predominantly Gleason 3 and PSA <10 in the absence of symptoms
Time to General Surgical Consultant Review Audit (Seven Day Services Clinical Standards – NHS England)	January 2019	• Consultant on call to review “take” patients in the evening (about 6-7pm) • Juniors reminded that every medical entry is dated, timed and signed • Re-audit April 2019
Review of Outcomes for Patients Undergoing Parotidectomy Surgery	January 2019	• Audit gave assurance that all standards for this surgery were met, complications are low and all patients were satisfied with their treatment • Follow up and recurrence rate for benign disease to be re-evaluated in 5 years (2024)
Incidence and Management of Post Dural Puncture Headache in Obstetric Patients Undergoing Neuro-axial Anaesthetic Procedure	January 2019	• Guideline on procedure to be updated to include discharge time after EDB (epidural blood patch) • Letter to GP to inform that may be suspicion of complications if any side effects of blood patch
Women and Children		
Neonatal HSV (Herpes Simplex Virus) and Sepsis	May 2018	• Improve documentation and accuracy of recording of birth weight • Positive GBS (Group B Streptococcus) results to be communicated to parents in a face to face meeting and a GBS leaflet to be given. To be documented in both mother and baby notes • Ensure that the follow up process at discharge for babies who

Local clinical audit	Month presented	Actions
		have been re-admitted to Orchard ward is adhered to • Guidelines in development outlining the management of hyponatraemia • Pharmacy developing guidance on the preparation and administration of 3% saline • Ensure flow charts are used for recording blood gas results and laboratory results • Improve record keeping and multidisciplinary team working
Congenital Cytomegalovirus (cCMV)	May 2018	• Staff training to ensure that appropriate use of testing to determine infection during the 3 week post-natal window is achieved by use of urine CMV PCR (protein creatinine ratio) for all cases screened • A guideline will be developed for use by the community audiology team to ensure babies who fail the second newborn hearing test within 2 weeks of birth are given a CMV urine PCR test
Audit of Paediatric SIs (2017 – 6 recorded)	May 2018	• New SOP (Standard Operational Policy) in place to address the findings of one incident • Revised induction for locum doctors in place • Improve patient safety by: o Increase staff confidence and delivering staff training in the recognition of the deteriorating patient o Offering more support and guidance to patients and families when making best interest decisions o Work in partnership with patients and relatives when complaints are raised to understand the key issues and be responsive to feedback o Give precedence to national and local audits in line with trust priorities
Fresh Eyes to CTG Interpretation	September 2018	• Staff to ensure that fetal heart monitoring (CTG) assessment tool is completed <u>hourly</u> alongside the Fresh Eyes buddy system for women with high risk labours and include: o Maternal pulse o Documentation on all assessment tools that escalation occurred to another clinician where the CTG was assessed as being suspicious or abnormal o Fetal blood sampling to be done where clinically indicated or documentation present if this could not be undertaken
Paediatric Sepsis Six	November 2018	• Training on completion of the proforma to be arranged for Riverbank clinical staff • To investigate possibility of integrating sepsis proforma into CAU (Children's Assessment Unit) proforma
Paediatric Diabetes Audit – Out of Hours Telephone Service	November 2018	• Improve awareness of the paediatric team regarding availability of the out of hours helpline and generate ideas on how the service can be improved • Promote the helpline to parents and families as a an additional source of support
Trustwide		
Hydration Protocol Awareness in CT with Contrast	September, November 2018 & March 2019	• To develop a Hydration Protocol guideline • Training sessions for foundation doctors to be arranged • Poster developed for display on wards
Pharmacy Led Initiative to Improve SACT (Systemic Anti-	March 2019	• JAC-CMS (JAC = Pharmacy Management Solution, CMS = Chemotherapy Management System) to make necessary changes in order to make SACT data fields mandatory • Re-audit once changes made

Local clinical audit	Month presented	Actions
Cancer Therapy) Compliance		
Patient safety		
Integrated Medicine		
Use of Raltitrexed in Bedford Hospital in Colorectal Cancer as per NICE recommendations	August 2018	• Documentation of written information given to patients in the clinical letter has been improved • Data on Raltitrexed use will continue to be collected prospectively as per NICE guidance
Lens Exclusion in Head CT	24 January 2019	• To undertake a review of the protocol for undertaking brain CT • Teaching and training of radiographers to ensure protocol is adhered to whereby no lenses are included in a routine CT when the examination of the orbit is not a requirement as per RCR guidelines
Drug Trollies: Safe & Secure Storage of Medicines	April 2018	• Poster highlighting best practice regarding safe and secure storage of medicines on the drug trolley devised and distributed to ward managers for displaying against ward drug trolleys • "Short date" stickers sent to wards to assist with highlighting packs close to expiry • All staff alerted to report on Datix any incidences where trolleys are noted to be unlocked/not immobilised • Only high frequency of use medications are to be held within drug trolleys (and therefore on ward stock lists) to help reduce the number of expired medications
Patient experience		
Integrated Medicine		
Acute Respiratory Assessment Service (ARAS) Patient Survey	July 2018	• Signage to the ARAS room has been improved
Early Supported Discharge Scheme (ESDS) Patient Survey	July 2018	• Referrals to the Pulmonary rehabilitation team will be increased to assist with patients having a good understanding of their lung condition • All patients are provided with British Lung Foundation information booklets • Respiratory Clinical Nurse Specialists (CNS) to ensure that all patients are offered a personal health care plan
Home Oxygen Service (HOS) Patient Survey	July 2018	• Findings fed back to BOC Home Oxygen Provider • Patients to be informed by telephone by the Respiratory CNS if their home visit appointment time is to be changed
Sleep Disruption on a Busy Medical Ward	November 2018	• Actively offer sleep packs in AAU • Look into possibility of minimising observations overnight for patients with NEWS scores of "0" or"1" • Developing and utilising "The Goodnight Guide"
Data Quality and Documentation		
Integrated Medicine		
Neurology	January	• Create training session/guidance on writing appropriate referrals

Local clinical audit	Month presented	Actions
Referrals	2019	according to BHT guidance to be delivered during induction week for new FYs/CTs to ensure for all referrals that: ○ there are at least 3 patient identifiers included ○ referrer name, grade/position and method of contact are documented
Planned Care		
Discharging Safely Under Maxims Re-Audit	September 2018	• Extramed to be phased out and upgraded to ICE to improve the quality of the discharge letters • Teaching session arranged on completion of the discharge letters for new FYI doctors • Discussion on cases and serious incidents involving discharge letters during audit meeting/M&M
Standard of Discharge Summaries T&O	January 2019	• Changes to be incorporated in the trust's computer program which assists with writing/auto populating discharge summaries
Women and Children		
Documentation	September 2018	• Brief interim reviews of notes to ensure that the documentation is complete and to pick up any inadequate records • Aim to file results in the patient's notes whilst patient still an inpatient so that they can be reviewed, signed off and filed appropriately • Alert sheet to be completed by the clinician in first contact with the patient • Information leaflets to be developed by the surgical team regarding emergency surgery
Adequate Completion of USS Requests in the Gynaecology Department	January 2019	• Flyers displayed in clinic rooms to prompt for inclusion of clinical details and clinical question to be answered when completing USS request forms in Gynaecology

Table 6: Local clinical audits and associated actions

2.5 Patient experience surveys and associated actions

Patient experience		
Integrated Medicine		
CT Virtual Colonoscopy	May 2018	• Patient leaflets to be available in larger print • Waiting area facility to be improved
Acute Respiratory Assessment Service	July 2018	• Discussed at Respiratory and Community team meetings • Signage to the ARAS room has been improved

(ARAS) Patient Survey		
Early Supported Discharge Scheme (ESDS) Patient Survey	July 2018	• Discussed at Respiratory and Community team meetings • Referrals to the Pulmonary rehabilitation team will be increased to assist with patients having a good understanding of their lung condition • All patients are provided with British Lung Foundation information booklets • Respiratory Clinical Nurse Specialists (CNS) to ensure that all patients are offered a personal health care plan
Home Oxygen Service (HOS) Patient Survey	July 2018	• Discussed at Respiratory and Community team meetings and findings fed back to BOC Home Oxygen Provider • Patients to be informed by telephone by the Respiratory CNS if their home visit appointment time is to be changed
Sleep Disruption on a Busy Medical Ward	November 2018	• Discussed at Integrated Medicine audit meeting • Actively offer sleep packs in AAU • Look into possibility of minimising observations overnight for patients with NEWS scores of “0” or”1” • Developing and utilising “The Goodnight Guide
Data Quality and Documentation		
Integrated Medicine		

Neurology Referrals	January 2019	• Discussed at Integrated Medicine audit meeting
		• Create training session/guidance on writing appropriate referrals according to BHT guidance to be delivered during induction week for new FYs/CTs to ensure for all referrals that:
		  ○ there are at least 3 patient identifiers included
		  ○ referrer name, grade/position and method of contact are documented

Planned Care		
Discharging Safely Under Maxims Re-Audit	September 2018	• Discussed at General Surgery audit meeting • Extramed to be phased out and upgraded to ICE to improve the quality of the discharge letters • Teaching session arranged on completion of the discharge letters for new FYI doctors • Discussion on cases and serious incidents involving discharge letters during audit meeting/M&M
Standard of Discharge Summaries in the Trauma and Orthopaedic Department	January 2019	• Discussed at T&O audit meeting • Changes to be incorporated in the trust’s computer program which assists with writing/auto populating discharge summaries
Women and Children		
Documentation: Paediatrics	September 2018	• Brief interim reviews of notes to ensure that the documentation is complete and to pick up any inadequate records • Aim to file results in the patient’s notes whilst patient still an inpatient so that they can be reviewed, signed off and filed appropriately • Alert sheet to be completed by the clinician in first contact with the patient • Information leaflets to be developed by the surgical team regarding emergency surgery
Adequate Completion of USS	January 2019	• Discussed at O&G audit meeting • Flyers displayed in clinic rooms to prompt for inclusion of clinical

Requests in the Gynaecology Department (Cycle 2)		details and clinical question to be answered when completing USS request forms in Gynaecology

Table 7:Patient experience surveys and associated actions

Monitoring of actions

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

National Audit of care at End of Life (NACEL)

The Trust participated in the National Audit of care at End of Life (NACEL), and the first rounds of results were recently published. The overarching aim of NACEL is to improve the quality of care of people at the end of life in acute, mental health and community hospitals.

The audit results are presented thematically in nine sections as demonstrated below and shows really positive results for the Trust. Green better than national score, red worse that national score.

Theme	National Summary Score	BHT Summary Score	
Recognition of dying	9.1	9.9	
Communication with dying patient	6.9	8.9	
Communication with family	6.6	8.8	
Involvement in decision making	8.4	9.3	
Needs of families and others	6.1	8.1	
Individual plan of care	6.7	9.1	
Families and others experience of care	7.1	5.1	
Governance	9.5	10.0	
Workforce/specialist palliative care	7.4	10.0	

Table 8: National Audit of care at End of Life (NACEL)

2.6 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 2018/19, 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 Heart Failure	100%
Perioperative Diabetes	91%
Pulmonary Embolism	58%
Bowel Obstruction	Study opens for data collection, request sent to clinicians.
Long term ventilation	No patients that matched the criteria.

Table 9:Bedford Hospital's participation in National confidential enquiry into patient outcome and death (NCEPOD)

2.7 Participation in clinical research

The number of patients receiving health services provided or sub-contracted by the Trust in 2018/19, that were recruited during that period to participate in research approved by a research ethics committee was 1,050. This includes both portfolio and non-portfolio studies. In addition to the above there are 826 patients in the follow up process.

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

The Trust was involved in conducting 28 clinical research studies in 2018/19 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 2018/19. These staff participated in research covering 11 specialties.

In the last three years, 101 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.

2.8 Commissioning for Quality and Innovation (CQUIN) framework

A proportion of Bedford Hospital NHS Trust's income in 2018/19 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 2018/19 five CQUINs applied to the Trust (listed in table 7). All were mandated nationally.

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

- Medicines Optimisation
- Dose Banding
- Secondary Dental
- NICU Testing Turnaround Times

Indicator identifier	CQUIN Name and description	Overall achievement of target (%) for 2017/18	Projected achievement of target (%) for 2018/19
1a	Improving staff health and wellbeing - Achieving a 5 percent point improvement in two of the three NHS annual staff survey questions on health and wellbeing, MSK and stress	0%	0%
1b	Healthy food for NHS staff, visitors and patients - Banning of price promotions on sugary drinks and foods high in fat, sugar or salt	100%	100%
1c	Flu vaccination - Improving the uptake of flu vaccinations for frontline clinical staff with Providers	100%	75%
2a	Timely identification of sepsis - The percentage of patients who met the criteria for sepsis screening and were screened for sepsis	50% of full payments however received partial payments	TBC
2b	Timely treatment for sepsis - The percentage of patients who were found to have sepsis in part 2a and received IV antibiotics within 1 hour	0% of full payments however received partial payments	TBC
2c	Antibiotic review - Assessment of a clinical antibiotic review between 24-72 hours of initiation in patients with sepsis who are still inpatients at 72 hours	100%	TBC
2d	Reduction in antibiotic consumption per 1,000 admissions	100%	TBC
4	Improving services for people with mental health needs who present to A&E	100%	100%

6	Offering Advice & Guidance - Offering A&G services for non-urgent GP referrals, allowing GPs to access consultant advice prior to referring patients into secondary care	50%	TBC
7	NHS e-Referrals - GP referrals to consultant-led 1st outpatient services only and the availability of services and appointments on the NHS e-Referral system	25%	Year one CQUIN only
8	Supporting proactive and safe discharge - Supporting the safe discharge of patients and the implementation of the Emergency Care Data Set (ECDS)	77.5%	Year one CQUIN only
9	Preventing ill health by risky behaviours - Screening, brief advice and referral for tobacco and alcohol	Second year CQUIN only	TBC

Table 10: Bedford Hospital NHS Trust achievement against 2017/19 CQUINs

2.9 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 underwent an inspection between July and September 2018 by the CQC and demonstrated significant improvements overall in the quality of patient care. Although, the overall rating remained 'requires improvement' the hospital achieved 80% good ratings for its services.

The inspection in 2018 was delivered under the new inspection framework and was:

- More tailored than previously, concentrating on those service areas rated requires improvement
- Fewer inspectors with more specialist experience
- Reviewed service quality and patient experience as well as separate 'use of resources' and 'well-led' domains.

While the overall rating of the hostile remained the same, the inspection came at a time of unprecedented activity for the hospital including:

- 4% extra attendances at A&E
- A&E built for 180 daily attendances – routinely receive 220 and have hit 280
- 7% more inpatient and 8% more outpatient attendances
- 5% fewer deaths
- Compliments out way complaints by nearly 30:1

Individual services improved from the 2015 inspection and three increased their rating to **GOOD**

- Children and young people
- Outpatients
- Surgery

And unfortunately, A&E moved from good to requires improvement.

Patient care

This inspection validates and highlights the good patient care and quality of services that the trust delivers daily to its patients. While it supports the ethos of delivering safe, reliable, high quality clinical services, it has reminded the trust not to be complacent and to continually develop additional improvements.

Assurance

During 2018/19 the trust continued to use a range of assurance tools to provide oversight on quality improvement which supports the detail of the CQC inspection@

- Improvement in clinical outcomes
- Reaccreditation of JAG certificate
- Internal and external inspections and peer reviews
- GIRFT (Getting It Right First Time) audits and visits
- National surveys/audits

The quality account of 2017/18 made reference to the impending merger between the trust and Luton and Dunstable NHS Foundation Trust. The CQC inspection outcome does not affect the strategic direction of preparing for the merger and strengthens the resolve that Bedford hospital delivers excellent clinical outcomes.

In addition, the inspection highlighted the trust was well-led (**GOOD**) with a clear vision, values and strategic direction for which the merger is central.

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.

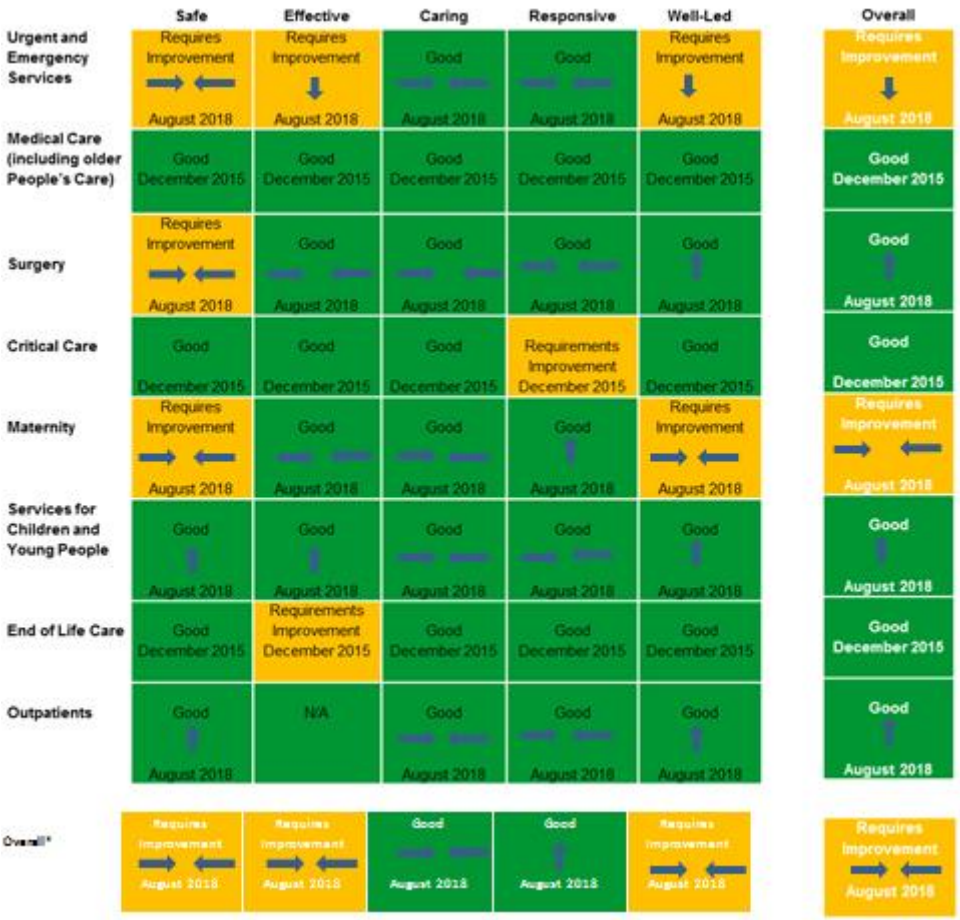


Figure 2: CQC inspection rating grid for Bedford Hospital (September 2018)

2.10 Duty of candour

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

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

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

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

Learning 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 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.

2.11 Sign Up To Safety

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

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

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

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

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

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

- Improve in-patient survey scores to show that patients are involved in choices about their care
- Report an increased satisfaction score for patients being treated with dignity
- Have an identified dignity champion for each ward/ department as a resource for staff, patients and relatives
- Ensure staff Friends and Family Test shows that staff feel valued as part of the care delivery team
- Ensure that clinical leadership development includes setting the quality agenda and quality improvement
- Ensure 95 percent of staff have an appraisal in which goals are aligned with the Trust's vision and values
- Ensure 95 percent of staff access induction which reflects the organisations vision, values and strategy
- Implement annual staff awards for quality
- Ensure that the board is visible and can be challenged through different channels
- Implement recommendations from Freedom to Speak Up are implemented in order to create an honest and open reporting culture
- Develop clear systems for reporting and learning from incidents.

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

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

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

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

The Trust will participate in regional and national quality and safety programmes to review and improve the care it gives to patients. The Trust will work with others, including the Trust's Patient Council and local Healthwatch organisations, to develop and improve understanding of measuring and monitoring safety and it will continue the collaborative work with commissioners and local community healthcare to reduce harm from pressure ulcers, supporting complex discharges and acute care in community settings.

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

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

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

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

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

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

- Incentivising and rewarding high quality care and quality improvement through promotion of vision and values, staff awards and listening events and roadshows.

2.12 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

- Freedom to Speak Up Guardian: 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.
- Bullying and harassment: During 2018 the Trust introduced a Peer to Peer Listening Service which reports 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. With an initial 12 volunteers it provides an informal and confidential line of support to staff, given from one colleague to another. 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. The service offers a safe space to talk about personal or work related problems and issues.
- Other means of staff support are provided through the chaplaincy team, trade unions and counselling service.

Feedback to those who speak up will be given to individuals through the Guardian role and 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.

2.13 Data quality

Bedford Hospital NHS Trust submitted records during 2018/19 to the secondary uses service for inclusion in the hospital episode statistics which are included in the latest published data. The percentage of records in the published data:

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

Information governance toolkit

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

Clinical coding accuracy

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

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

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

2.14 Learning from deaths

There were 603 deaths in Bedford Hospital NHS Trust up to the end of 2018/19 quarter three. Deaths per quarter are as follows.

- 209 in the first quarter
- 178 in the second quarter
- 216 in the third quarter
- Quarter 4 data will be reported to trust board in July 2019.

By March 2019 (quarter 3), 329 case record reviews have been undertaken. It should be noted that this will not be a final figure due to the lag time in undertaking some reviews.

The number of deaths in each quarter for which a completed case record review has been undertaken to date is:

- 131 in the first quarter
- 98 in the second quarter
- 100 in the third quarter

To date, two of the 603 deaths were judged to be more likely than not to have been avoidable. One of these cases was ascertained as probably avoidable following a coroner's inquest. One further death which was subjected to a coroner's inquest occurred after transfer to a tertiary centre.

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

- deaths in the emergency department; and
- stillbirths.

Process for review

Deaths of children are subject to review under the Child Death Overview Process (CDOP) and therefore not included in trust mortality reviews. Although deaths involving patients with learning difficulties are using the LeDER methodology, due to the delay in this process internal mortality reviews are undertake in these cases.

The trusts' medical director is the executive lead for learning from deaths. In line with NHSI guidance, quarterly reports on learning from deaths have been tabled at trust board since October 2017. These assurance reports provide oversight of both the statistical information and learning from those deaths classed as avoidable. The Learning from Deaths policy was published on the external trust web site in September 2017.

The trust disseminates the medical notes from each patient death across the consultant body in the hospital for review of both care and treatment and assessment of avoidability of each death. Each review is carried out using an electronic mortality review tool with NCEPOD grading of quality of care and determination of a preventability score. Themes from reviews are presented to trust board and triangulated with serious incident investigation outcomes. Case reviews are presented for discussion at clinical audit days and speciality mortality meetings.

What we have learnt from case record reviews and investigations conducted in relation to the deaths
The trust's Learning from Deaths board reviews the outputs from mortality reviews as well as a number of mortality metrics. Reviews at specialty/condition level are commissioned as required.

The trust seeks to learn from all deaths. Themes that arose from case reviews where care could have been improved include:

- Poor documentation and assessment
- Handover and appropriate communication
- Failure of making appropriate DNAR/TEP decisions

An assessment of the impact of the actions
Action plans from serious incidents are monitored within clinical divisions and reported through quality board. Actions and improvements arising from mortality reviews are monitored through the Mortality Surveillance Group and escalated to Learning from Deaths board.

2.15 National indicators in care quality 2017/18

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 11: Five domains of the NHS Outcomes Framework

2.16 Our performance against 2017/18 quality indicators

Eight Quality Account indicators apply to Bedford Hospital NHS Trust in 2018/19:

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

2.17 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.

	2016/17	2017/18	2018/19
Bedford Hospital NHS Trust	1.033 Band 2 ‘as expected’	1.041 Band 2 ‘as expected’	1.057 Band 2 ‘as expected’

	25.3% palliative care	26.3% palliative care	27.9% palliative care
England average	1.00	1.00	1.00
Best performing Trust	0.690 Band 3 'lower than expected'	0.727 Band 3 'lower than expected'	0.691 Band 3 'lower than expected'
Worst performing Trust	1.164 Band 1 'higher than expected'	1.247 Band 1 'higher than expected'	1.268 Band 1 'higher than expected'

Table 12: Summary Hospital-level Mortality Indicator (SHMI) for Bedford Hospital

Source: Health and Social Care Information Centre

(https://indicators.ic.nhs.uk/webview)

Notes:

- 2016/17 data = October 2015 to September 2016 (published March 2017)
- 2017/18 data = October 2016 to September 2017 (published March 2018)
- 2018/1918 data = October 2017 to September 2018 (published Feb 2019)

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

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

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

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

2.18 Patient Reported Outcome Measures (PROMs)

Domain 3

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

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

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

Groin hernia surgery

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

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

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

	2016/17	2017/18	2018/19
Bedford Hospital NHS Trust	0.067	Not applicable(less than 6 record)	NA
England average	0.087	0.089	Not available
Best performing Trust	0.12	0.136	Not available
Worst performing Trust	0.006	0.029	Not available

Table 13: Patient Reported Outcome Measures (PROMs) for Groin Hernia surgery

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

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

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

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

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

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

Varicose vein surgery

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

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

	2015/16	2016/17	2017/18
Bedford Hospital NHS Trust	-4.17	-0.544	Awaiting publication (Aug 2018)
England average	-8.6	-8.61	Awaiting publication (Aug 2018)
Best performing Trust	-13.14	-18.075	Awaiting publication (Aug 2018)
Worst performing Trust	4.26	2.117	Awaiting publication (Aug 2018)

Table 14: Patient Reported Outcome Measures (PROMs) for Varicose Vein surgery

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

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

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

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

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

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

Hip replacement surgery

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

Each of the 12 questions on the Oxford Hip Score and Oxford Knee Score are scored in the same way with the score decreasing as the reported symptoms increase, i.e. become worse. All questions

are presented similarly with response categories denoting least (or no) symptoms scoring four and those representing greatest severity scoring zero.

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

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

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

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

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

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

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

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

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

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

Knee replacement surgery

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

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

Worst performing Trust	12.40	12.231	Awaiting publication (Aug 2018)

Table 16: Patient Reported Outcome Measures (PROMs) for knee replacement surgery

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

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

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

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

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

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

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

2.19 Emergency readmissions to the hospital within 28 days of discharge

Domain 3

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

	2015/16	2016/17	2017/18	2018/19
0 to 15 years of age	8.5%	9.19%	7.98%	7.83
16 years and over	10.7%	7.4%	7.68%	8.10

Table 17: Emergency readmissions to the hospital within 28 days of discharge

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

Notes:

There is an ongoing 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.

- 2015/16 - data provided via CHKS source – admitted patient care dataset

- 2016/17 - data provided via CHKS source – admitted patient care dataset
- 2017/18 - data provided via CHKS source – admitted patient care dataset
- 2018/19 - data provided via CHKS source – admitted patient care dataset

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

- The Trust accepts the published data

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

- The Trust will continue to review 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.

The NHS Outcomes Framework Indicators - February 2019 Release; states the following:

2.20 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.

	2016/17	2017/18	2018/19
Bedford Hospital NHS Trust	65.1%	64.2 %	Awaiting publication
National average	68.1%	68.6 %	Awaiting publication
Best performing Trust	85.2%	85.0 %	Awaiting publication
Worst performing Trust	60.0%	60.5 %	Awaiting publication

Table 18: Responsiveness to the personal needs of patients

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

Notes:

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

- Data for 2018/19 is unavailable.

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

- The Trust awaits publication of data for 2018/19 to understand where to focus its improvements.

2.30 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.

	2016/17	2017/18	2018/19
Bedford Hospital NHS Trust	72%	67%	71%
England average	70%	71%	71%
Best performing Trust	85%	86%	87%
Worst performing Trust	49%	47%	40%

Table 19: Percentage of staff who would recommend the Trust to friends or family needing care

Source: Picker Institute Staff Survey

Notes:

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

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

2.31 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.

	2016/17	2017/18	2018/19
Bedford Hospital NHS Trust	97.64%	98.02%	97.65%
England average	95.6%	95.26%	Awaiting publication
Best performing Trust	100%	100%	Awaiting publication
Worst performing Trust	79.14%	77.78%	Awaiting publication

Table 20: Percentage of admitted patients who were risk assessed for venous thromboembolism

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

Notes:

2017/18 - not yet published nationally

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

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

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

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

2.32 Rate of Clostridium difficile infections

Domain 5

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

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

The scope of the indicator includes all cases 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 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.

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

- Prompt identification and escalation 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 standards agreed with the CCG
- Timely specimen collection from the patient
- Utilising an infection prevention and control admission risk assessment form.

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

- Working closely with education and training department to ensure 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

	2016/17	2017/18	2018/19

Bedford Hospital NHS Trust	8.25	7.7	6.0 provisional data
England average	13.2	13.7	Not available
Best performing Trust	0	0	Not available
Worst performing Trust	82.7	91.0	Not available

Table 21: Rate of Clostridium difficile infections

Source: www.gov.uk/government/statistics/clostridium-difficile-infection-annual-data

2.33 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.

	2016/17	2017/18	2018/19
Bedford Hospital NHS Trust	39.7 incidents	35.5 incidents	Not available
National average	Not available	42.6 incidents	Not available
Best performing Trust	0.01 incidents	24.2 incidents	Not available
Worst performing Trust	69.0 incidents	124.0 incidents	Not available

Table 22: Percent of patient safety incidents per 1,000 bed days

	2016/17	2017/18	2018/19
Bedford Hospital NHS Trust	0.14%	0.41%	Not available
National average	0.38%	0.37%	Not available
Best performing Trust	0.00%	0.20%	Not available
Worst performing Trust	0.53%	1.55%	Not available

Table 23: Percent of patient safety incidents resulting in severe harm or death

Notes:

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

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

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

2.34 Serious Incidents – reducing patient harm

Domain 5

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

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

Bedford Hospital NHS Trust takes this responsibility seriously and is continually strengthening its safety culture to ensure that serious incidents are reported and investigated thoroughly. The Trust reports all serious incidents and never events to Bedfordshire Clinical Commissioning Group and provides an investigation report, outlining the openness and transparency through duty of candour; root causes of the incident; lessons learnt; and action plans to prevent recurrence of the incident, within sixty working days.

Serious incidents declared in 2018/19

During the financial year 2018/19, the Trust declared a total of 45 serious incidents compared with 34 in 2017/18.

A breakdown of the categories of Serious Incidents that occurred in 2018/19 is presented in table 24.

Type of incident	Number of Serious incidents
Falls	10
Diagnostic incident including delay	6
Surgical Never Events	6

Baby/child born in poor condition requiring transfer out	5
Delay in treatment	4
Medication Incident	3
Complication of procedure	3
Intrapartum death	2
Pulmonary Embolism	2
Delayed monitoring/observation	1
Pressure Ulcer	1
Screening Incident	1
Other	1
Total	45

Table 24: Categories of Serious Incident that occurred in 2018/2019

2.35 Safety Thermometer (ST)

Safety Thermometer

Safety thermometer is a tool to measure, monitor and analyse patient harm and 'harm free' care, falls is one element reviewed within safety thermometer

Falls

Domain 5

In 2018/2019 there were zero deaths from a fall. There were nine severe harm falls that were investigated under the SI process, and five patients that suffered moderate harm. This is a point prevalence survey carried out nationally and 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
Rate per 1000 bed days Total harm cumulative	1.22	1.05
Rate per 1000 bed days Total falls	5.46	4.78

Number	620	659

Table 25: 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 (point prevalence survey) 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 0.5%, as a trust we have fluctuated above the national line on 2 occasions 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 3.5% harm on one occasion in the last 12 months.

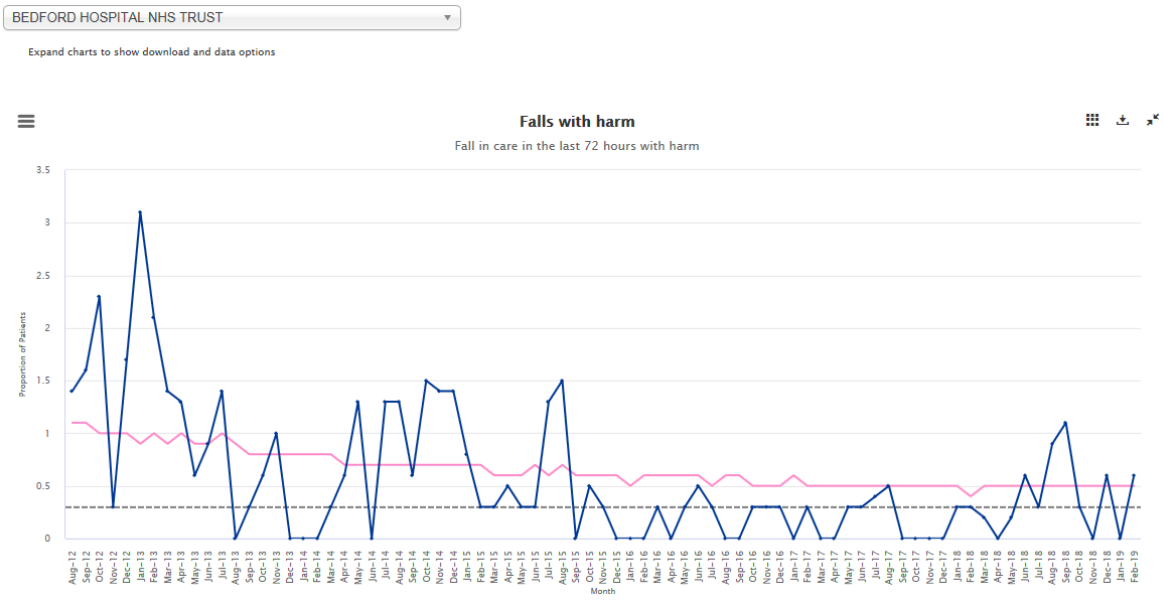


Figure 3: Falls with harm

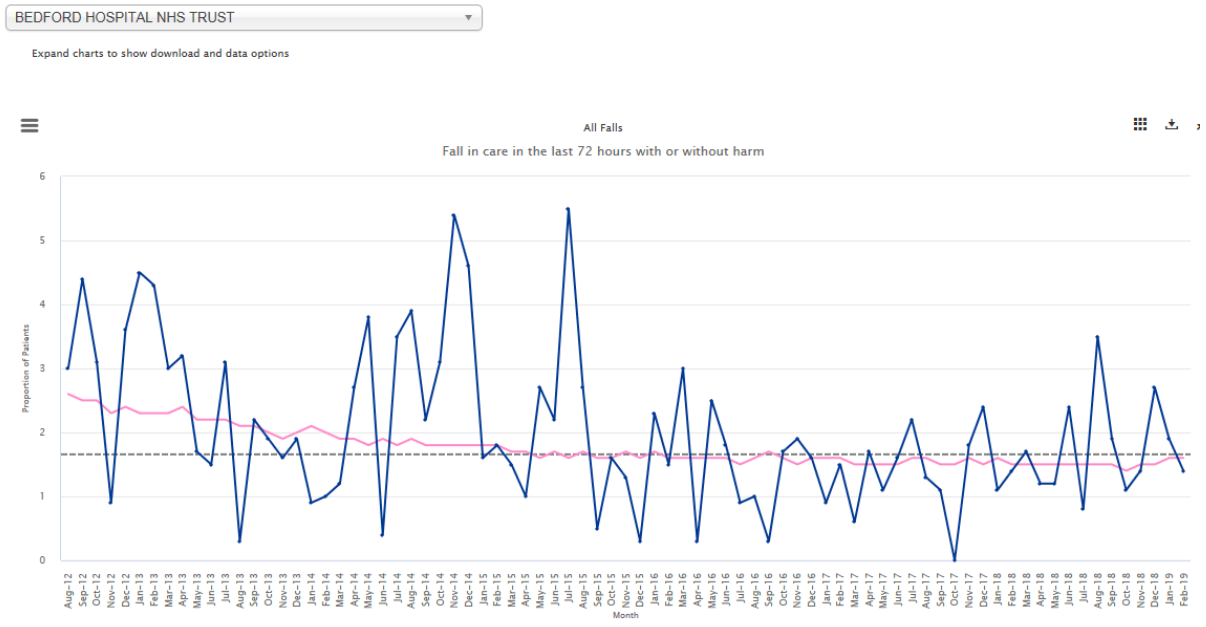


Figure 4: All Falls

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
A quality improvement program has been developed entitled 'Focus on Fall's' to address the areas of recommendations. From May 2018 two high risk wards bi-monthly have taken part in this initiative.
A number of broken down initiatives are circulated throughout the month that aim to raise awareness, decrease the risk of a patient falling and reduce overall falls:

Focus on falls plan

- Week 1- Ensure every patient over 65yrs old receives a Falls leaflet on admission and falls placemats are distributed at mealtimes for all high risk patients, as appropriate
- Week 2- Ensure every patient over 65 yrs. old has a lying/ standing BP on admission and it is recorded in relation to falls. A vision assessment is completed.
- Week 3 - All patients over 65 yrs. have a medication review in relation to falls and it is recorded, and post take ward round paperwork is up to date if applicable
- Week 4- Intentional rounding is in place and recorded throughout night shifts and high risk times

Daily quality falls rounds, undertaken by falls lead/ nominated staff member, ensuring:

- Patient has suitable footwear on
- Call bell is in reach
- Patient tray is in reach
- Mobility aid is in reach if required
- Patients are dressed if appropriate before 1130
- Regular intentional rounding
- Falls and bed rail assessments are completed
- Increased staff support/ education via falls lead and champions
- Introduction of mobility posters and vision assessments

Pressure Ulcers (ST)

Domain 5

Safety thermometer is a tool to measure, monitor and analyse patient harm and 'harm free' care, pressure ulcers are one element reviewed on a specific date (point prevalence survey) every month; safety thermometer looks at pressure ulcers from two aspects; pressure ulcers that develop whilst the patient is in hospital and then the total number of pressure ulcers present on admission.

New guidance was published by NHSI in 2018 which has been implemented. Pressure ulcers will be defined as; New Pressure Ulcers (previously known as hospital acquired pressure ulcers) and improve wound management. The term avoidable and unavoidable are no longer in use.

The first graph looks at pressure ulcers that developed whilst the patient was in hospital**;** since August 2018 we have been below the national line consistently; our harm rates have been between 0.3 - 0.6%.

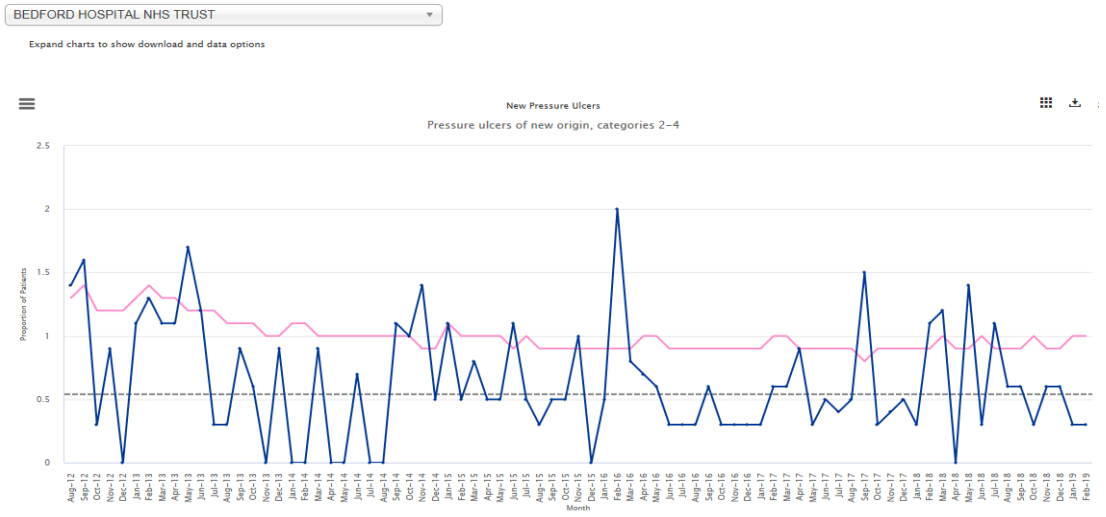


Figure 5: New pressure ulcers

The second graph looks at all pressure ulcers that are present in the trust on the safety thermometer date, national line for harm is 4.3-4.6% as a trust we sit above the national line which has fluctuated from 4.4-8.7% harm, this includes all pressure ulcers that are present on admission as well as new pressure ulcers developed whilst the patient has been in hospital.

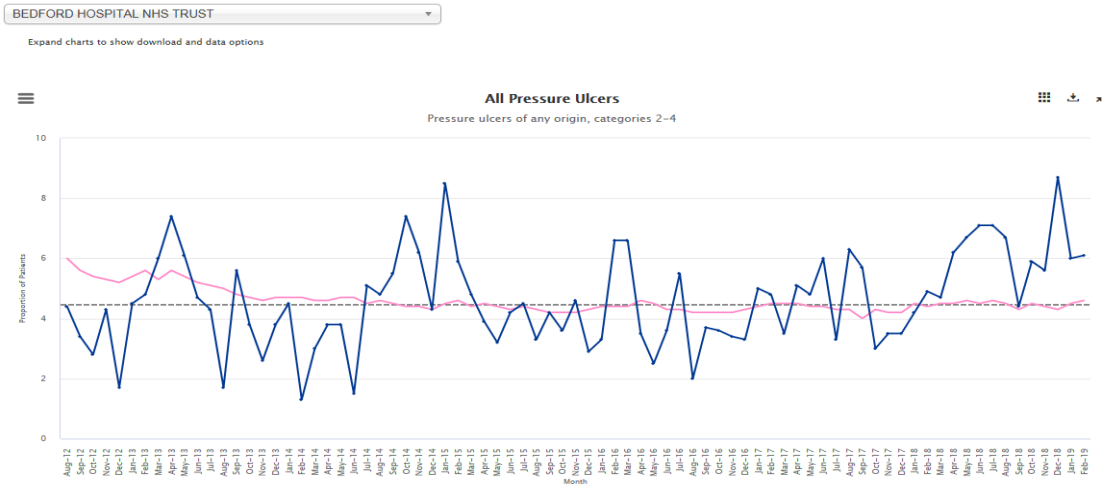


Figure 6: all pressure ulcers

Quality improvement initiatives;

- Pressure ulcer risk assessments are monitored monthly by matrons in the nursing quality dashboard. This is reported to the Quality Board and by exception to Quality and Clinical Risk Committee
- A central database tracks all Hospital Acquired Pressure Ulcers (HAPU) and progress against trajectories
- Link Nurses are now established and quarterly study days are attended well.
- Implementation of all new NHSI guidelines allowing for more robust reporting and learning from both pressure ulcer and Moisture associated skin damage
- Implementation of new IAD pathway and use of barrier creams to effectively prevent and manage Incontinence associated skin damage

- Regular attendance to the patient safety committee
- New innovations for offloading heels reviewed and trial scheduled
- Collaborative working with the CCG, East of England Ambulance Service and Local hospitals.
- Change in RCA process to ensure more rapid learning and ease of completion
- Newsletter to update and inform staff

Training;

- Wound assessment workshops focus on moisture damage and pressure ulcers together with wound assessment, allowing education of causation, assessment and management.
- Study days to share learning and current practice for TVN link nurses
- Clinical update mandatory training

After extensive work within the tissue viability service, we have now seen a reduction in incidents of unavailable dynamic mattresses and appropriate escalation to ensure patients receive appropriate equipment in a timely manner. This is ongoing and we continue to adapt process to ongoing need. We have secured funding for further dynamic air cushions which were made available end of last year. Annual audits of the trust foam mattresses saw a decline in condemned mattresses, showing appropriate checking and usage

Collaborative working

The trust has worked with the CCG, community and Luton and Dunstable Hospital to improve and maintain the wound care and formulary. The benefits of the formulary include:

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

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.
- Improve care and treatment of chronic leg wounds – this will be as part of the leg matters week early next year.
- Introduce digital photography for all wounds, to monitor progress
- Re-launch of the Tissue Viability Service – an event highlighting the service, and all provisions available to clinical staff.
- Ensure one to one access day for each link nurse to further up skill, assurance of visibility within their clinical area and contingency planning
- A neighbouring trust peer reviewed the trusts TVS and this feedback will be used to formulate the quality improvements for the following year

2.36 Drug incidents

Domain 5
There were six serious incidents that involved medication issues declared in 2018/19. The six incidents were relating to different drugs/themes as follows:

- Omission of diuretic medication in a baby at discharge
- Cardiology patient and allergic reaction to IV contrast
- Patient with sepsis, abnormal clotting and subsequent intracranial bleed
- Incorrect administration of adrenaline during an anaphylactic reaction and subsequent MI
- Insulin Dependent Diabetic who developed Diabetic Ketoacidosis (DKA) following omission of insulin.
- Hypoglycaemia and ITU admission following intentional overdose of insulin

As a result of these serious incidents, the Trust is undertaking the following:
Omission of diuretic medication in a baby at discharge

- Trust wide Standard Operating Procedure for writing discharge prescriptions to be developed
- Teaching included in Paediatric induction programme
- Case discussion locally through team and quality meetings

Cardiology patient and allergic reaction to IV contrast

- Review of the safety checklist in the cardiac catheterisation suite
- Review, update and relaunch of the departments current care pathway documentation
- Refresher training for staff working in cardiac catheterisation suite on how to manage anaphylaxis and emergency situations
- Case discussion locally through team and quality meetings

Patient with sepsis, abnormal clotting and subsequent intracranial bleed

- Dissemination of a patient safety alert
- Review of Trust Warfarin guidelines to improve the information on emergency reversal
- Review of Trust Blood transfusion policy
- Develop changes to the laboratory practice concerning communication of urgent clinical information to clinicians

Insulin Dependent Diabetic who developed Diabetic Ketoacidosis (DKA) following omission of insulin

- Case discussion local and through Trust wide audit sessions
- Teaching included in induction programme

Insulin Dependent Diabetic who developed Diabetic Ketoacidosis (DKA) following omission of insulin

- Refresher training on the treatment of anaphylaxis
- Teaching on anaphylaxis to be included on face to face resuscitation training
- Dissemination of patient safety alert
- Case discussion local through team and quality meetings

Hypoglycaemia and ITU admission following intentional overdose of insulin
Currently under investigation

2.37 Never events

Never Events declared in 2018/19:

The Trust declared 6 Never Events in 2018/19. A summary of these is listed in the table below.

Case	Learning

Incorrect prosthesis and knee replacement surgery	The importance of having clear and consistent prosthetic verification standards that are adhered to by the whole team. The importance of having clear standards for the use of loan kits and clarifying the role of Company representatives in prostheses verification checks prior to implantation. The importance of timely entry of data on the National Joint Registry (NJR) system post orthopaedic surgical procedures.
Incorrect toe incision	The importance of ensuring that the surgical site marking policy is strictly adhered to and that the digit to be operated on is surgically marked to clearly indicate the site of surgery. Ensuring that the “time out” part of the surgical safety checklist in undertaken properly.
Retained vaginal swab	Engagement from the multidisciplinary team with the Surgical Safety Checklist and the checking process. Surgery should not be presumed to be over until the sign out is completed. Updating and relaunch of the WHO checklist in theatres has been completed. The importance of good communication and team working amongst the multidisciplinary theatre team. Foster a culture of challenge amongst all team members.
Angioplasty undertaken on incorrect side	Consent for Interventional Radiology Procedures to be obtained in line with the Trust’s Consent Policy. Ensuring that the use of the Surgical Safety Checklist in Interventional Radiology is embedded. Review of the current SOP for performing peripheral angioplasties to ensure it is compliant with Trust and national guidance i.e. NatSSIPs. The importance of timely incident reporting and escalation of potential serious incidents.
Incorrect removal of a tooth in an adult	The importance of implementing the WHO checklist in OMF Outpatient Department Theatre (implemented post incident) The importance of radiographs being displayed in an easily visible area in the theatre environment so that the whole theatre team can view. Nursing staff to be more involved in the checking process and question the operator if necessary. If a tooth is indeed already missing, this should be recorded in the Outpatient Department notes or alternatively, record all teeth present.

Incorrect removal of a tooth in a child	When a patient is first seen in the Outpatient Clinic, there needs to be more accurate record-keeping in relation to the position and status of the teeth that will subsequently support the surgeon with pre-operative checks. The importance of ensuring that a recent radiograph is available prior to surgery that shows clearly the transcription of the teeth. For Orthodontic extractions and particularly with buried teeth consider obtaining a 3D image in the form of a Conebeam CT scan as this gives improved clarity but less radiation for a child. Review the feasibility of having a paper print of an up to date x-ray (OPG) available before surgery that could be marked with the tooth to come out as part of the consenting process. Radiographs should be displayed in an easily visible area in the theatre environment for all to see and check prior to tooth extraction.

Table 26:Never Events declared in 2018/19:

Themes from above Never Events:

The overarching theme from the Never Events in year relates to use of and embedding of the surgical safety checklist in all areas where interventional procedures are undertaken, including areas outside of the theatre environment. Other themes included:

- The importance of engagement of the whole theatre team and good communication during the checking process in ensuring that robust checks are undertaken.
- The importance of fostering a culture of challenge so that staff feel able to speak up and challenge when required.
- Human error and the importance of staff training on human factors elements and how these contribute to errors. A programme of human factors training has been delivered to theatre staff.
- The importance of good record-keeping.
-

Safety Improvement Work in Theatres:

Work to improve the safety culture and robustness of the surgical safety checks undertaken in theatre commenced following the first Never Event. The following actions were implemented:

- Review, updating and relaunch of the Surgical Safety Checklist on 26.6.18.
- Empowerment of theatre staff to challenge behaviour and speak up. Weekly Theatre Group meetings implemented to review and discuss any issues/areas of concern.
- Leadership and senior theatre staff presence in the theatre environment to monitor and challenge the quality of checks being undertaken. Daily spot checks undertaken by theatre manager and team leaders.
- Matron appointed to cover the theatre environment.
- Increased vigilance and incident reporting to capture near misses.
- Observational audits undertaken to observe practice and identify human factors. Introduction of a “mystery shopper” in February 2019.
- Provision of Human Factors training to theatre staff.

- Development of a Theatre Culture Group to review and improve behaviours and cultural issues in theatres.
- Development of a Theatre Safety Group to oversee and monitor progress with implementation of the safety improvement work. This includes oversight of Policies, SOP's and Theatre Practice Standards.

2.38 Complaints

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

A formal complaint involves a thorough investigation following which the Chief Executive responds directly to the 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 in which to complete an investigation and respond to the complainant. Most complaints were responded to within 30 to 40 working days, several days sooner than our target; this was driven by feedback from complainants who felt they had to wait too long for a response. The Trust is committed to maintain the response time of 30 – 40 working days.

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 clinicians. However If the Trust's further efforts to resolve the matter are deemed unsatisfactory they are advised that they can refer their complaint to the Parliamentary and Health Services Ombudsman (PHSO).

Overview

The Trust has seen a downward trend in complaints over the previous years and continues to improve and develop its process in the following ways:

- Staff training at clinical update
- Management of concerns through PALS
- Identify and share themes to inform staff of trends and areas where actions/service improvements can be made
- 'Look, Listen and Learn' messages for staff are highlighted in the Chief Executive's weekly newsletter
- Doctors training
- Complaints managers forum

East of England Deanery Higher Speciality training

East of England, Deanery Higher Speciality Training – The Management of Complaints and Litigation.

To improve understanding of complaints and local resolution the Trust's litigation and complaints manager delivered a training session for the ED Registrars in November 2018. The session was very well received and subsequently invited the trust to deliver 'The Management of Complaints and Litigation' at the East of England Deanery Higher Speciality Training (Regional Training Day) in January 2019 at Addenbrooke's Hospital in Cambridge. This was targeted teaching using case studies from previous ED complaints/claims. It was a very engaging and interactive session and the feedback was that it was found to be insightful, interesting and beneficial.

The trust hosted the national complaints mangers forum in March 2019

The CEO opened the event with a welcoming and charismatic speech and some high profile guest speakers included the Parliamentary and Health Service Ombudsman.

Their presentations spanned subjects around complaints and resolution that included mediation, mental health and gender identity and we also explored the reasons why people claim compensation. The day concluded with a joint workshop by NHSR and the PHSO from which further developments in NHS complaint handling will emerge.

Around 90 delegates came from Dorset to Doncaster and many places between, representing GPs, Dentists, CCGs, Mental Health and Acute Hospital Trusts and the feedback they gave us highly praised the location, venue, food and the content of the agenda. They found all Bedford Hospital staff to be welcoming and attentive.

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 2018/19 the Trust had three new complaints referred to the PHSO and they re-opened an old complaint at the request of the complainant as it was felt that their investigation was flawed:

- One complaint was upheld because the patient's blood test results were not communicated effectively; this did not impact on the physical wellbeing of the patient but it impacted upon the patient's emotional wellbeing. This was thought to be a level two injustice for which the Trust was instructed to apologise and pay the patient £450.00.
- Three cases remain under investigation.

This compares to the previous year when six complaints were investigated by the PHSO; three were partially upheld and three were not upheld. In the previous year sixteen complaints were referred to the PHSO; twelve were not upheld, three were partially upheld and one was upheld. Therefore year on year we are seeing less cases being referred to the PHSO which would suggest the complaint handling is thorough and robust and the Trust responses to be acceptable in the main.

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 formal response.

In 2018/19 the Trust registered 998 PALS concerns compared to 1,327 the previous year.

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 a

- During 2018/19 the Trust strengthened the learning from complaints process by embedding the use of a 'learning table' in response letters from the Chief Executive.
- A monthly quality improvement newsletter (QI) is circulated to all staff by email and hard copies are taken to each department by volunteers
- A weekly newsletter from the Chief Executive to all staff highlights 'Look, Listen and Learn' messages from complaints and concerns
- Learning is shared at mandatory staff training at induction, clinical updates and targeted training at ward and departmental level
- The complaints team participate in training staff in root cause analysis, statement writing and giving evidence at coroner's court
- The complaints team participate in regional doctors' training focusing on complaints, claims and statement writing.
- The Trust hosted the National NHS Complaint Manager's Spring Conference.

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

Next steps

- To sustain and then further reduce the target response time to below 35 working days.
- To improve complainant satisfaction, by showing how their complaint has improved services for other service users. Both of these actions will be monitored by the Complaint Satisfaction Survey.
- Continue to engage with staff to ensure prompt local resolution to respond and further reduce concerns
- Improve patient experience by responding effectively when things go wrong and sharing good practice when patients have a good experience
- To continue to share and embed the learning from complaints/concerns and claims through reporting, training and Trust-wide cultural awareness.

2.39 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 2019/20 the Trust will continue to:

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

2.40 National surveys

Inpatient cancer survey 2018;

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 2019/20

Maternity survey 2018;

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

- Women need to be fully informed of their options concerning place of birth
  The maternity unit has a plan in place to address these themes and has achieved the following;
- Survey staff perception of information giving regarding place of birth

Actions

- Advertise choice of birth place, home, midwifery led units or hospital prior to pregnancy or very early pregnancy through GP surgeries in poster format
- Open day celebrating Better Births and Choice and personalisation

- Training and appointment of a Professional Midwifery Advocates (PMA) who provide a debriefing service for parents that wish to reflect on their experience and also consider future pregnancies and options for their birth plans
- Choice of place for birth needs to be discussed at referral to maternity care supported by written literature and revisited in a supportive manner at booking and throughout the antenatal care pathway as women may change their mind.
- A leaflet will be given to all community midwives to help generate discussions around choice of place of birth. This will be supported by workshops on around how to have the conversation, especially around women across boarder

Children and young people's survey;

The 2018 survey data is being analysed at time of this report and publication is due in October /November 2019

Inpatient survey 2018

Following the national inpatient survey, which sampled patients during 2018, regarding different aspects of care and treatment, the initial report provided by the Picker institute.

The CQC will publish their benchmarked report, that will compare our patient's responses nationally and is expected in May/June 2019

Part Three: The quality services provided by BHT

Part three of the Quality Account includes information to demonstrate the quality of services provided by the Trust

3.0 Quality improvements

Therapy Dogs

The trust has been welcoming Beanz the Chihuahua, and his best friend Cody the Golden Retriever who visit patients on Harpur, Elizabeth, Russell and Arnold Whitchurch Wards, with their owner Sarah on Thursdays and occasional Fridays. They are both trained and accredited by Therapy Dogs Nationwide and have a lovely calm and happy temperament, ideal for visiting elderly patients who thoroughly enjoy the attention they can give and gain from our new volunteers.
Using dogs and other animals as therapy isn't a new concept and has been benefitting people in all walks of life and different care situations for some 40 years since a lady named Lesley Scott-Ordish pioneered the concept.

Owner of the Therapy dogs Sarah comments;

> *'The delight on patients faces when they see the dogs is one of the most satisfying things I get from bringing my dogs to visit. They elicit a sense of happiness throughout the ward, and the pleasure the patients get from stroking and touching the dogs is the most rewarding thing to watch. So many emotions flash across their faces, as they remember their pets from both past and present and it opens a torrent of memories.'*

Ward staff look forward to Thursdays and Fridays just as much as our patients. The beneficial impact of dogs has been really noticeable. They bring smiles to patient's faces and in some cases, patients who have been predominantly non-verbal due to dementia have spoken to the dogs whilst stroking and engaging with them. Beanz and Coby seems to evoke many happy memories of when they had a dog themselves and the physical interactions also appear to induce calmness even with some of our more generally agitated patients. They are a real asset and this therapy has demonstrated clear benefits to our patients.

It's really amazing to see the difference they make not only with our patients with Dementia but all patients who may be missing a beloved pet at home. Staff absolutely love having them on the ward too, they really are uplifting.

Beanz

Coby

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

Johns Campaign

The aim of the campaign is to give carers of those living with dementia the right to stay with them in hospital, in the same way that parents stay with their sick children. Hospital admissions can be unexpectedly difficult times for people with dementia or frailty.

We recognise the key role that relatives and carers have in helping us to plan and deliver person-centred, safe and effective care. We have found that whatever supports our patient's personal well-being is likely to make their medical treatment more effective and will promote their secure discharge.

Carers can help with:

- Explaining what treatment or intervention is going to happen.
- Provide reassurance to relax when being examined.
- Complete a 'This is me' document to support staff to understand your relatives preferences.
- Help with washing, dressing or eating.
- Hold their hand whilst they settle for the night. Overnight facilities are limited but we have purchased recliner chairs on the 4th floor to enable carers to have somewhere comfortable to rest

Research has found there are also many quantifiable benefits:

- Reduction in the incidence of delirium
- Reduction in falls
- Improvement in hydration and nutrition
- Better communication
- Willingness to accept treatment
- Improvement in management of continence
- Improved recognition of pain
- Maintenance of movement and general functioning
- Reduction in complaints
- Better discharge

Johns Campaign is in progress on Harpur, Elizabeth, Arnold Whitchurch and Russel wards will a plan to roll out to all wards during dementia awareness week in May 2019

End of life care

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

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

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

Ward reconfiguration

During 2018 an analysis of beds by speciality was undertaken, this resulted in clarifying the trusts need for more medical speciality beds and a reduction in surgical beds. On the newly configured trauma ward the average length of stay reduced.

RHW - number of patients with a length of stay of 7 days or more.

	16/07/2018	23/07/2018	30/07/2018	06/08/2018	13/08/2018	20/08/2018	27/08/2018	03/09/2018	10/09/2018	17/09/2018	24/09/2018	01/10/2018	10/08/2018	15/10/2018	22/10/2018	29/10/2018	05/11/2018	11/12/2018	19/11/2018	26/11/2018	03/12/2018	12/10/2018	17/12/2018	24/12/2018	31/12/2018	07/01/2019	14/01/2019	21/01/2019	28/01/2019	04/02/2019	11/02/2019	18/02/2019	25/02/2019	04/03/2019	11/03/2019
RHW	22	17	23	26	25	25	19	20	23	23	24	18	26	21	21	25	18	17	15	15	18	13	13	13	15	17	15	14	16	14	12	14	11	14	13

↑
POST WARD RECONFIGURATION

Figure 7: RHW number of patients with a length of stay of 7 days or more

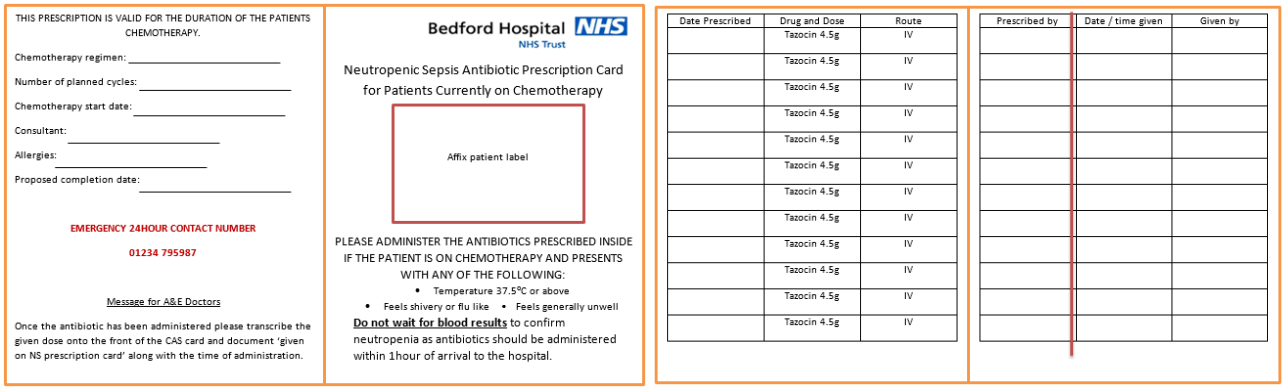
Between July and October the mean average number of patients with a length of stay of 7 days or more was 27. Post ward reconfiguration from November to March 2019 the mean average number of patients with a length of stay of 7 days or more is 13.89.

How was this achieved?

- Nursing team with a new focus
- Robust MDT's that are regular and well run.
- Consultant and team based on the ward and very much part of ward 'life'
- Excellent working relationship between ward manager and consultant.
- Reduction in the number of outlying patients.

Improving treatment for oncology patients with Sepsis

A neutropenic sepsis antibiotic prescription card has been implemented. The card has a signed prescription by the oncologists for the appropriate antibiotic depending on the patient's allergies and is given to patients prior to commencing chemotherapy. If patient attends A&E with suspected neutropenic sepsis the pre-signed prescription enables the triaging nurse to facilitate immediate antibiotic administration.



THIS PRESCRIPTION IS VALID FOR THE DURATION OF THE PATIENTS CHEMOTHERAPY.

Chemotherapy regimen: _____

Number of planned cycles: _____

Chemotherapy start date: _____

Consultant: _____

Allergies: _____

Proposed completion date: _____

EMERGENCY 24HOUR CONTACT NUMBER

01234 795987

Message for A&E Doctors

Once the antibiotic has been administered please transcribe the given dose onto the front of the CAS card and document 'given on NS prescription card' along with the time of administration.

Bedford Hospital NHS
NHS Trust

Neutropenic Sepsis Antibiotic Prescription Card for Patients Currently on Chemotherapy

Affix patient label

PLEASE ADMINISTER THE ANTIBIOTICS PRESCRIBED INSIDE IF THE PATIENT IS ON CHEMOTHERAPY AND PRESENTS WITH ANY OF THE FOLLOWING:

- Temperature 37.5°C or above
- Feels shivery or flu like
- Feels generally unwell

Do not wait for blood results to confirm neutropenia as antibiotics should be administered within 1hour of arrival to the hospital.

Date Prescribed	Drug and Dose	Route
	Tazocin 4.5g	IV
	Tazocin 4.5g	IV
	Tazocin 4.5g	IV
	Tazocin 4.5g	IV
	Tazocin 4.5g	IV
	Tazocin 4.5g	IV
	Tazocin 4.5g	IV
	Tazocin 4.5g	IV
	Tazocin 4.5g	IV
	Tazocin 4.5g	IV
	Tazocin 4.5g	IV
	Tazocin 4.5g	IV

Prescribed by	Date / time given	Given by

Multi-disciplinary Diabetic Foot Team

Multi-disciplinary Diabetic Foot Team has commenced as part of national improvements. Those patients with diabetic foot ulcers that are admitted are seen in a timely manner and the tissue viability nurse and diabetic podiatry lead work closely together to ensure appropriate care is provided. We have also introduced a neuropathic foot assessment for all patients with diabetes to be completed on admission, this is now being used on some wards and with further training should be imbedded into normal working practice within all departments caring for admitted patients. This should see a reduction in ulcers.

Maternity

HSIB (Health care Safety Investigation Branch) began operating on 1 April 2017. The team are experienced safety investigators, led by the chief investigator. They conduct investigations into incidents and accidents that take place within NHS funded care in England.

Their National investigations do not replace local investigations and are focused on looking at the wider opportunities to learn from exploring where harm may or has happened. They work with patients and their families and carers, healthcare staff, trusts, hospitals and other healthcare providers across England.

Bedford has now been included with the 18 March 2019 as the roll out date, their Maternity investigations do replace local investigations which meet the 'Each Baby Counts' criteria or a direct or indirect maternal death during or within 42 days of the end of pregnancy.

Babies meeting the criteria are:

- Babies who are "cooled" and transferred to a tertiary centre
- Intrapartum deaths of term infants
- Unexpected Neonatal deaths of term infants

Historically the trust would have conducted these investigations either as serious incidents or internal investigations but this will be undertaken now by the team from HSIB. The trust has not had any cases to date since the 18th March meeting the criteria.

Still births

We have produced a paper which is being tabled at Quality Board, but in summary we have had a significant reduction in the stillbirth rate over the last two years.

Jan 2017 - Dec 2018 we had 15 still born babies with 3 term babies included within the numbers leaving us with a still birth rate of 5.23 per thousand

Jan 2018 – Dec 2018 we had 11 still born babies with 1 term baby included within the numbers leaving us with a still birth rate of 3.88 per thousand

There is an expectation that Trusts will achieve a 20% reduction in still births by the year 2020 and as you can see we have achieved a 26.6% reduction locally. There remains work to be carried on but this is a real achievement.

All stillbirths and neonatal deaths must now be investigated using a national investigation tool kit called the PMRT (perinatal mortality review tool). All local cases are investigated using this method

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 2018 survey was 44% (1246 staff) which is up from 39% in 2017 against an overall national response rate average of 47% trust. The staff engagement score of 7.1 is just above average across acute trusts.

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

	Top 5 scores (compared to Picker average)
59%	Q19g. Supported by manager to receive training, learning or development definitely identified in appraisal
29%	Q19b. Appraisal/review definitely helped me improve how I do my job
58%	Q4f. Have adequate materials, supplies and equipment to do my work
56%	Q5h. Satisfied with opportunities for flexible working patterns
39%	Clear work objectives definitely agreed during appraisal

	Most improved from last survey
59%	Supported by manager to receive training, learning or development definitely identified in appraisal
35%	Appraisal/performance review: definitely left feeling work is valued

37%	Satisfied with level of pay
56%	Organisation treats staff involved in errors fairly
38%	Appraisal/performance review: organisational values definitely discussed

	2016	2017	2018	Average	Trust
Supported by manager to receive training, learning or development definitely identified in appraisal	52%	50%	59%	54%	59%
Appraisal/review definitely helped me improve how I do my job	26%	26%	29%	24%	29%
Have adequate materials, supplies and equipment to do my work	62%	59%	58%	54%	58%
Satisfied with opportunities for flexible working patterns	58%	54%	56%	52%	56%
Clear work objectives definitely agreed during appraisal	39%	37%	39%	35%	39%
Appraisal/performance review: definitely left feeling work is valued	32%	28%	35%	32%	35%

	2016	2017	2018	Average	Trust
Satisfied with level of pay	37%	30%	37%	36%	37%
Organisation treats staff involved in errors fairly	53%	51%	56%	59%	56%
Appraisal/performance review: organisational values definitely discussed	35%	33%	38%	37%	38%

	Bottom 5 scores (compared to average)
55%	Don't work any additional paid hours per week for this organisation, over and above contracted hours
64%	Appraisal/performance review: training, learning or development needs identified
56%	Organisation treats staff involved in errors fairly
40%	Don't work any additional unpaid hours per week for this organisation, over and above contracted hours
65%	Able to provide the care I aspire to

	Least improved from last survey
63%	Receive regular updates on patient/service user feedback in my directorate/department
28%	Organisation definitely takes positive action on health and well-being
46%	Last experience of harassment/bullying/abuse reported
71%	In last 12 months, have not experienced musculoskeletal (MSK) problems as a result of work activities
68%	In last month, have not seen errors/near misses/incidents that could hurt patients

	2016	2017	2018	Average	Trust
Don't work any additional paid hours per week for this organisation, over and above contracted hours	57%	58%	55%	64%	55%
Appraisal/performance review: training, learning or development needs identified	73%	63%	64%	69%	64%
Organisation treats staff involved in errors fairly	53%	51%	56%	59%	56%

Don't work any additional unpaid hours per week for this organisation, over and above contracted hours	47%	44%	40%	42%	40%
Able to provide the care I aspire to	73%	67%	65%	68%	65%
Receive regular updates on patient/service user feedback in my directorate/department	64%	70%	**63%**	63%	63%
Organisation definitely takes positive action on health and well-being	37%	34%	**28%**	28%	28%
Last experience of harassment/bullying/abuse reported	49%	51%	46%	45%	46%
In last 12 months, have not experienced musculoskeletal (MSK) problems as a result of work activities	74%	76%	**71%**	72%	71%
In last month, have not seen errors/near misses/incidents that could hurt patients	75%	73%	68%	70%	68%

In terms of the overall national results, the Trust has performed better than average in five of the 10 themes, average in four and slightly below average in one theme as the graph shows below.

In terms of NHS organisations in the East of England, Bedford Hospital featured as most improved in terms of support from immediate manager and overall staff engagement.

The Listening in Action (LiA) scatter map measures how staff rate leadership and culture based on data from the national staff survey. It has four quadrants and can be analysed as follows:

- The higher up you are the better the Trust is performing against peers in the eyes of the staff
- The further to the right you are, the more positive your trend year on year.

The Trust is pleased that our position has improved in 2018 moving from the bottom of the top left quadrant into the top right hand quadrant.

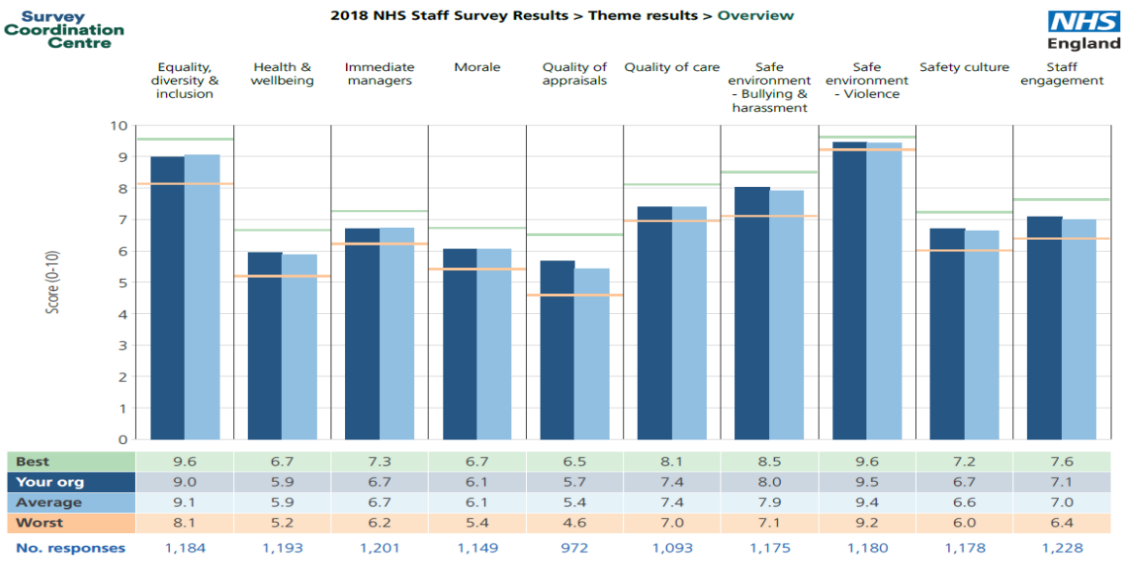


Figure 8: 2018 Staff Survey results - Overview

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, 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 19/20 will incorporate the actions arising.

3.1 Seven Day Services Clinical Standards

Seven Day Services

In 2013, the Seven Day Services forum, chaired by Sir Bruce Keogh, identified ten clinical standards that all patients should expect to receive when during an emergency admission to hospital, regardless of the time of day or day of the week they are admitted. The overarching aim of the programme is to reduce variation in clinical quality that can arise through the differences in service provision on weekdays and weekend.

Of the ten clinical standards, four were subsequently identified as priority standards that all acute trusts providing consultant-led care should be consistently achieving:

Clinical standard	What this means for patients
Clinical standard 2: Time to first consultant review	All patients admitted as an emergency should be reviewed by a consultant within 14 hours of admission to hospital.
Clinical standard 5: Access to consultant directed diagnostics	Patients should have access to consultant-directed diagnostics (ultrasound, CT, MRI, echocardiogram, endoscopy and microbiology) seven days per week. Results should also be reported seven days per week. Timeliness of provision of

	diagnostics according to the need of the patient: - Critical patients within one hour - Urgent patients within 12 hours - Non-urgent patients within 24 hours
Clinical standard 6: Access to consultant directed interventions	Patients should have timely access to the following interventions seven days per week: - Critical care - Interventional radiology - Interventional endoscopy - Emergency general surgery - Emergency renal replacement therapy - Urgent radiotherapy - Stroke thrombolysis - Percutaneous Coronary Intervention - Cardiac pacing (either temporary via internal wire or permanent) These services can be provided on-site or at other nearby hospitals (e.g under network arrangements with one hospital providing the service for a number of hospitals).
Clinical standard 8: Ongoing consultant review	Patients with high-dependency needs should be reviewed by a consultant twice per day. Patients with a clear clinical pathway should be reviewed once per day. The daily review can be delegated to a suitably senior clinician (e.g. senior registrar) if the consultant has determined that this will not affect the patent's pathway.

Table 27: Seven day services

Bedford Hospital achievement of Seven Day Services priority clinical standards

In line with the reporting arrangements set out by NHS England, the trust has completed twice yearly audits to assess its achievement of the priority clinical standards and to support improvement actions. Until early 2019, this involved an audit of a defined number of patients over a seven day period. NHS England piloted a new approach in February 2019 which involved a self-assessment against the four priority clinical standards. The self-assessment was reviewed and approved by the Trust Board.

The next evidence submission is due in late June 2019. This will take the same format as the February 2019 submission and will again require approval by the Trust Board.

Clinical Standard 2: First consultant review

The Trust performance against this standard is provided in the table below.

	Weekday	Weekend
March 2016	79%	72%
September 2016	90%	67%
March 2017	77%	71%
September 2017	66%	62%
April 2018	64%	62%

Table 28: Clinical Standard 2: First consultant review

During the April 2018, Trust has identified one of the key issues driving the decline in performance as the quality of documentation within acute medicine (e.g. omission of the time of the first review).

As a result, clinicians developed an action plan to address the issues. Local re-audits were completed in August 2018 and January 2019 which have showed an improvement in the percentage of patients reviewed within 14 hours, linked to improved record keeping:

Acute medicine	April 2018	August 2018	January 2019
Weekday	69%	70%	79%
Weekend	68%	77%	95%

Table 29: 7 day services - Acute medicine

Following the local improvement activities within acute medicine, the Trust has commenced similar improvement work in general surgery.

Performance in general surgery was better in January 2019 compared to May 2018, but still below the Clinical Standard. Generally, documentation quality was acceptable within this specialty. However, the Trust is aware that the availability of consultant cover in the early evening challenges its ability to meet this standard. The June 2019 evidence submission will be used to support a wider programme of work around improving provision across a 24 hour period.

General surgery	May 2018	January 2019
Weekday	50%	59%
Weekend	33%	44%

Table 30: Seven Day Services - General Surgery

Clinical Standard 5: access to diagnostic tests

The Trust's achievement of clinical standard 5 is provided below. Where a diagnostic test is not available on site or off-site via a formal arrangement, further details are provided.

	Weekday	Weekend
Microbiology	Available on site	Available off site via formal arrangement
Computerised Tomography (CT)	Available on site	Available on site
Ultrasound	Available on site	Test not available
Echocardiogram	Available on site	Available on or off site via informal arrangement
Magnetic Resonance Imaging (MRI)	Available on site	Available on or off site via informal arrangement
Upper GI endoscopy	Available on site	Available on site

Table 31: Clinical Standard 5: access to diagnostic tests

Ultrasound

Ultrasound services are provided 8am to 8pm Monday to Friday. Outside of these hours, patients are placed on the list for the next working day. In order to meet the standard for critical and urgent patients the Trust would need to invest in a resident sonographer/radiographer.

Echocardiography

Echocardiography services are provided 8am and 4.30pm Monday to Friday. Patients in a critical condition can receive an echocardiogram within 1 hour within these hours. By informal arrangement,

the on-call cardiologists will undertake critical echocardiograms at weekends and out of hours. Complex patients are transferred to the local tertiary centre as required. In order to achieve the 1 hour and 12 hour standard the Trust would require a formalised system, and the 24 hour standard for non-urgent patients would require an on-call weekend technician.

Magnetic Resonance Imaging (MRI)

MRI services are provided 8am to 8pm seven days a week. Outside of these hours, critical patients are transferred to a tertiary centre. However, travel time to the tertiary centre is greater than on2 hour. In order to meet the critical, urgent and non-urgent standards, the Trust would require an extension of MRI operational hours to 24 hours per day, outsourcing of out of hours MRI reporting (aside from MRI for cord compression which can be reported by neurosurgeons at the tertiary centre), and an increase of 4 WTE Band 6 radiographers to ensure 24/7 cover.

Clinical Standard 6: Consultant directed interventions

The Trust meet all requirements to provide consultant directed interventions seven days per week either on site or via a formal arrangement with a nearby hospital, apart from interventional radiology.

	Weekday	Weekend
Critical care	Available on site	Available on site
Interventional radiology	No formal arrangement out of hours	No formal arrangement out of hours
Interventional endoscopy	Available on site	Available on site
Emergency surgery	Available on site	Available on site
Emergency renal replacement therapy	Available on site	Available on site
Urgent radiotherapy	Available off site via formal arrangement	Available off site via formal arrangement
Stroke thrombolysis	Available off site via formal arrangement	Available off site via formal arrangement
Percutaneous coronary intervention	Available off site via formal arrangement	Available off site via formal arrangement
Cardiac pacing	Available on site	Available off site via formal arrangement

Table 32: Clinical Standard 6: Consultant directed interventions

Clinical standard 8: ongoing consultant review

Patients should be reviewed by a consultant once every day during their inpatient stay. Patients of high acuity and high dependence should receive twice daily reviews when specified by the consultant.

In April 2018, the Trust's performance was as follows:

	Weekday	Weekend
% patients required twice daily review AND received 2 reviews	81%	75%
% patients required once daily review AND received one	81%	49%

review		

Table 33: Clinical standard 8: ongoing consultant review - April 2018

Next steps
In order to meet the requirement to provide NHS England with a board-assured submission in late June 2019, the Trust planned and undertook an audit against the four priority standards in late April 2019. At the time of writing, the findings were yet to emerge and formal plans to address any issues will be developed in due course.

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

Since the announcement was made in Autumn 2017 of our plans to merge with Luton and Dunstable Hospital University Hospital (L&D), the partnership approach established with the L&D Hospital continues with real progress made in exploring the opportunities this will bring.

Various Clinicians, Managers, members of the Trust Board from both hospitals have been working together as well as GP, social care and community service partners to find new collaborative approaches that will benefit patients.

Although we still await the final outcome of the capital funding request submitted to NHS Improvement to continue with plans to merge and create a single Foundation Trust, collaborative working between both Trusts continue to progress.

Plans are underway for an integrated NHS pathology service across the whole of Bedfordshire which will drive innovation and efficiencies to improve patient experience and outcomes. The priority is to ensure we continue to provide a safe, high quality service for GPs and patients during this transition so we have extended our contract with Viapath, who have been providing pathology services at Bedford Hospital since 2009, to March 2020.

3.3 Summary of Bedfordshire, Luton and Milton Keynes (BLMK) Sustainability and Transformation Plan (STP) 2018/19

BHT is part of the Bedfordshire, Luton and Milton Keynes (BLMK) ICS. In carrying out planning, all BLMK organisations have committed to having plans that are cost reducing, realistic, sustainable, transparent, collaborative, credible, evidence-based and that show a return on investment. The BLMK ICS has five priority work streams and our contribution to each is briefly set out here:

- Priority 1 Prevention: We will embed prevention to support both patients and staff – including supported self-assessment of prevention, the dissemination of work-place wellbeing principles and delivery of personalisation training for staff.
- Priority 2 Delivering high quality and resilient primary, community and social care services: We will support the development of primary care networks by aligning our staff to support multidisciplinary care at network level.
- Priority 3 Sustainable Secondary Care: We will continue work to improve cancer and maternity services within the ICS.

- Priority 4 Digitalisation: We will participate in the development of a shared care record solution for the population we serve.
- Priority 5 System Re-design: We will explore options for more integrated provision with other providers and consider the case for new payment mechanisms to incentivise integrated working.
- During 2019 a BLMK long term plan will be developed and we will be leading conversations with staff and the public to help develop this plan.
- Finally, we recognise the call for mutual aid between organisations in the NHS Long Term Plan and commit to working constructively with partners in BLMK.

3.4 Statements of assurance from the board

Review of services provided by Bedford Hospital NHS Trust

Annex one: services provided by Bedford Hospital NHS Trust in 2018/19

Service Description	
Accident and emergency	
Blood transfusion	Ophthalmology***
Breast Surgery	Oral maxillofacial
Cardiology	Orthodontics
Cardiac cath suite	Paediatrics
Chemical pathology*	Pain management
Colorectal surgery	Phlebotomy
Critical Care Medicine (CC)	Plastic surgery
Dermatology	Podiatry (diabetic outpatients)****
Diabetic medicine	Rheumatology
Ear Nose and Throat (ENT)	Screen services - AAA, Retinopathy, bowel
Elderly care	Trauma and orthopaedics
Endocrinology	Tunable dye laser treatment
Endoscopy unit	Upper gastro-intestinal
Gastroenterology	Urology
General medicine	Vascular
General pathology*	**Clinical Support Service departments services**
General surgery	Audiology
Gynaecology	
Hepatology	

Haematology*	
Histopathology*	Dietetics
Immunopathology*	Orthotics*****
Lower gastro-intestinal	Ret inal screening
Medical oncology	Service departments
Microbiology*	Occupational therapy
Midwifery	Pharmacy
Neonatal	Physiotherapy
Nephrology**	Speech and language therapy****
Neurology	Theatres
Obstetrics	Acute admissions unit

* indicates a laboratory service provided by Viapath
** indicates a service provided by Lister Hospital - East and North Hertfordshire NHS Trust
*** indicates a service provided by Moorfields Eye Hospital NHS Foundation Trust
**** indicates a service provided by Essex Partnership Trust (EPUT)
***** indicates a service provided by Patterson Healthcare

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

Central Bedfordshire Council Statement

Bedford Borough Council statement

Bedford Borough Council overview and scrutiny committee

Statement from Bedfordshire Clinical Commissioning group

Healthwatch Bedford Borough

Healthwatch Central Bedfordshire

Annex three: statement of directors' responsibilities

Annex four: external audit limited assurance report

Annex five: acronyms and abbreviations

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

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

NAS	Neonatal Abstinence Scoring
NASH	National Audit Of Seizure Management
NBOCAP	National Bowel Cancer Audit Programme
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
PACC	Professional Association Of Clinical Coders
PALS	Patients' Advice And Liaison Service
PAR	Patient At Risk
PCA	Patient Controlled Analgesia
PCNL	Percutaneous Nephrolithotomy
PHSO	Parliamentary And Health Service Ombudsman
PHP	Personal Health Plans
PLACE	Patient Led Assessment Of Care Environments

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

Contents – tables and figures