Bedford Hospital NHS Trust

Appendix B

Bedford Hospital NHS Trust

Quality Account 2016 / 17

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Part three:

Part one: Statement on quality from the chief executive

I am pleased to present the quality account for 2016/17. Over the last year, the trust has improved its performance significantly in many areas thanks to the dedication of our staff and the support of our patients. We really appreciate the support of our local community and partner organisations such as Friends of Bedford Charity and Healthwatch for their unfailing commitment to support the important services provided by and in Bedford Hospital NHS Trust.

It has been a successful yet challenging year for the trust, where we have seen ever increasing numbers of patients through our doors, especially as emergency admissions and A&E attendances; this has in turn put significant pressure on our services across the hospital.

I am incredibly proud of the fact however, that despite these, at times, overwhelming operational pressures, we have maintained results in the upper quartile of the country by focusing on improving the systems and processes underpinning the quality of care our patients receive.

Bedford Hospital has a single quality improvement strategy which integrates recommendations of the Care Quality Commission (CQC) in its report published in April 2016 with our own quality priorities. All actions related to quality and safety is implemented in a consistent and robust way across the organisation.

I am pleased to say that we have implemented all of the four CQC Requirement Notices and the majority of the remaining recommendations. The completed action plan was sent to the CQC, NHS Improvement and the Clinical Commissioning Group at the end of January 2017.

Aligned to this, we implemented a monthly integrated performance report for our trust board which gives a robust overview of all key areas and enables the board to better scrutinise the impact of the changes we have implemented on patient care. A range of key quality indicators are supported by exception reports and discussion of specific issues; this includes maternity indicators arising from a new maternity services dashboard. This dynamic report allows clinical quality and patient experience to be measured alongside financial performance and workforce information, as well as the relationship and impacts of each on the other.

Some key quality achievements for 2016/17 include:

- The reduction in serious incidents from 2015/16
- The significant reduction in complaints and the decision of the Parliamentary and Health Service Ombudsman investigations in favour of the trust
- Dementia ward (Harpur and Elizabeth wards) accreditation – recognising the support given to older people by the quality mark from the Royal Colleges of Psychiatrists and Physicians

- Development of the ambulatory care unit
- The implementation of Red/Green days
- Preparations for new scanner from charity which will be operational in 2017/18

Running in parallel, there have been a number of initiatives which have further driven our quality improvements and which we should be very proud of - namely our patient safety programme (run in conjunction with the University of Bedfordshire), the implementation of best practice protocols for staff training, and a recruitment drive resulting in fewer nurse vacancies requiring agency cover.

It has been as important as ever this year to listen to our patients, visitors, staff, volunteers, regulators and partner organisations as part of our efforts to drive improvements. We do this by carrying out surveys, learning from investigations when things go wrong, dealing with complaints and recording compliments, and working closely with patient representation groups such as Healthwatch and our own Patients' Council. Looking forward, we will use the feedback gained this year to develop our priorities and focus on the areas that require further improvement as part of the final year of our quality improvement strategy.

Our progress to date and our ambitions moving forward has only been possible thanks to the hard work of all of our staff and volunteers, who continually show a fantastic commitment to improving the quality of our patient care. I am looking forward to working with our teams' right across the trust next year as we implement yet more improvements for our patients.

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

Stephen Conroy, Chief Executive

Part two: Quality improvement priorities 2016/17

In the 2015/16 quality account the trust identified three quality improvement priorities for 2016/17 based on the outcome and recommendations of the trust's CQC inspection. The actions that delivered on the outcomes underpinned the quality improvement strategy's priorities and the top three that were identified are:

- Patient safety: improve learning following never events, incidents and complaints to prevent avoidable harm.
- Patient experience: build on good practice in maintaining privacy, dignity and respect in outpatient areas and further improve the range of patient information in languages other than English.
- Clinical effectiveness: improve the implementation of plans to improve outcomes against national audits.

The trust's progress in achieving these improvement priorities is presented in pages 8 to 13

Patient safety priority for 2016/17: improve learning

In the 2015/16 quality account the trust identified a priority to improve learning following never events, incidents and complaints to prevent avoidable harm.

Progress made in 2016/17

The CQC inspection provided an opportunity for the trust to review the development of a learning culture.

Access to learning comes from a range of sources including:

- Incidents
- Complaints
- Serious incident investigation
- Clinical audit
- Good practice

To understand good practice the trust carried out scoping with partner organisations that have positive learning experiences and cultures especially around those identified by the CQC as good or outstanding.

Culture

To ensure the trust identified immediate learning to ensure patient safety, serious incident investigations (SI) were centralised. While investigations continued to have a senior clinical lead, centralising the investigation meant that immediate learning was identified and themes linked to various clinical areas highlighted that may not have been if investigations had happened locally.

The trust's clinical governance team historically focused on patient safety, risk and incident management but focus changed in 2016/17 to shared learning. This meant working with clinical divisions and nursing to support identifying factors that may contribute to patient harm and to reduce the risk of re-occurrences which can be seen in the reduction of Si, complaints and thematic reviews of incident themes.

In year, the trust appointed two clinical governance business partners who support the divisions to establish speciality quality groups and other infrastructure, to understand the root causes of harm and therefore how to change processes to prevent recurrence of similar incidents. The business partners have also worked with the communications team to establish a cascade infrastructure to ensure flow of information through divisions and ensure that front line staff have access to learning from outcomes and understand that behaviour change is driven as a result of learning. The flow of information from our board to ward and ward to board has ensured that not just learning is shared but a sense of ownership of the behaviour change.

To support cultural change, all new staff inductions and clinical updates include shared learning with examples of quality and process improvements implemented following previous learning and how to identify incidents of harm report it and ensure robust investigation of current incidents and dissemination of learning to prevent future harm.

There were five audit half days in which the findings were presented and outcomes from clinical audits to help shape clinical practice and in some cases treatment. The audit days were attended by clinical staff, in particular consultants and junior doctors and are usually held within a speciality. All audit days have a centralised trust-wide presentation regarding incident management and learning which feeds discussion and debate about practice.

During the year the trust expanded its development of its SI investigation process in continuing RCA (root cause analysis) training with courses held during the year. The purpose of the training is to ensure that key staff understand the principles and values of a good investigation and how to develop the findings into outcomes for learning and action plans. This has improved the quality and consistency of our SI investigations.

The training now incorporates 'human factors' where staff understand how teamwork, tasks, working environment, and individuals' learning can impact and affect actions and incidents. Understanding the foundation of human factors can help a wider knowledge of contributing factors while undertaking an investigation; and therefore provide an opportunity for a more considered approach to prevent reoccurrences by helping staff understand what went wrong with practical ways for avoiding similar occurrences.

During the year the trust welcomed the CQC report 'Learning from deaths' and the principles of patient involvement, openness and transparency are already central to the trust's values and current process. The central principles are included in the 16/176 quality strategy and we will continue to review and revise as needed.

The trust launched the QI (quality improvement newsletter) in October 2015 which shares learning on a monthly basis across the hospital to all clinical staff. To date 18 editions of the newsletter have been published and key topics covered include: anticoagulation, deteriorating patients, sepsis, falls and safeguarding has a theme across the edition and will present examples of cases, either an inquest or an incident which will support understanding of what influenced the incident and how staff can prevent it happening again.

Supporting the development of QI, learning is also shared through 'information triangles' within the trust restaurant where both staff and members of the public can see how the trust uses learning and feedback to further develop safe services and improve the patient experience.

A number of specialities have been supported in developing newsletters for their area which provide staff with a sense of ownership of information and incidents. Linking these newsletters to the trust wide quality improvement team has given opportunities for wider shared learning throughout the trust.

We recognised the need to strengthen the repository of learning on the trust intranet, where staff will be able to access both examples of learning but also the background to the learning incident. Implementation is underway and carried forward to 16/17 improvement plan.

The trust uses Datix as the incident management system and substantial work has taken place during the past year to improve the dynamics of the system so it supports learning. Workflow through the DatIx system have been implemented/improved and incident investigations and reporting back to staff on the outcome of the investigations is faster allowing earlier implementation of learning and change at front line level.

Further development of the Datix mortality module now allows clinical peer-reviews on all hospital deaths to be electronically recorded, root cause analysis performed robustly and any findings shared automatically.

In addition to training staff, the trust has improved the robustness of validation of incident data to provide more assurance as well understanding the true extent of patients harm. For example, a clearer understanding of harm caused by medication errors, rather than simply recording a failure of providing TTOs (discharge medication) has helped us provide assurances that harm to patients from medication errors is and remains very low.

There is an annual plan of thematic reviews and spotlights on emerging issues to establish common themes and influences so that the trust can develop and mitigate against patient harm. Oversight of this process is by a sub-committee of the board – quality and clinical risk committee (QCRC).

Patient experience priority for 2016/17: maintaining privacy, dignity and respect

In the 2015/16 quality account the trust identified a priority to build on good practice in maintaining respect for patients by ensuring privacy and dignity in outpatient areas and further improve the range of patient information in languages other than English.

Progress made in 2016/17

Privacy and dignity

The CQC identified an issue with a lack of privacy and dignity for patients, particularly in outpatients where at times female patients had to sit in hospital gowns in a waiting area where other patients, including males, were clothed. In addition, some ward areas had reduced washing facilities for personal care.

We undertook an immediate review of all areas and implemented good practice including:

- Patients currently waiting in this area no longer wear a gown until they go into the scan room to maintain privacy and dignity.
- Reviewed and changed information that patients received prior to coming to hospital so they would be aware of the what clothes to wear for specific appointment and ensured that had access to private sitting areas if they chose to wear a gown between tests
- Communicated to all staff to raise awareness within all staff groups involved in the provision of breast clinic services
- Use of privacy clips for curtained areas
- Used internal intelligence to identify areas where patients have feedback, complained, about issues for privacy and dignity the review showed there were no complaints received in a six month period.
- Reviewed sound proofing in examination rooms to ensure patients are not overheard. A problem in phlebotomy did identify a problem and the service was moved from main outpatients to Weller Wing where both privacy and capacity have been enhanced
- Development of the Cauldwell Centre in Weller Wing providing patients with on-site direct access to primary care

To support our implementation of good practice, we invited Healthwatch Bedford along with other partners including patient council and CCG, to carry out ‘enter and view’ inspections. The inspections, which took place over a number of months, identified in the final report that patients feel they are treated with privacy and dignity.

Accessible patient information

Following data collection from the (most recent) 2011 census and the number of translation episodes we have provided since January 2016; the trust identified the top six languages for the hospital catchment area as:

- Polish (113 translation episodes since January*)
- Punjabi (79 translation episodes since January*)
- Italian (26 translation episodes since January*)

- Bengali (15 translation episodes since January*)
- Lithuanian (12 translation episodes since January*)
- Romanian (11 translation episodes since January*)

Since September 2016 the trust reviewed both models of communications – patient leaflets – as well as the accessibility of that information. The trust identified the top ten leaflets used by patients and had those translated into the top six languages as well as provided access of those leaflets through braille and easy to read.

The leaflets are available at service level as well as through the internet.

Clinical effectiveness priority for 2016/17: improve outcomes against national audits

In the 2015/16 quality account the trust identified a priority to improve the implementation of plans to improve outcomes against national audits

Progress made in 2016/17

During 2016/17, 45 national clinical audits covered relevant health services that the trust provides and it participated in all 45 (100%) of these national clinical audits. Of these, 32 audits comprise continuous data collection and are therefore undertaken annually.

For the remaining 13 audits these are created by the royal colleges on an annual basis to reflect current priorities such as:

- Royal College of Emergency Medicine (RCEM) focusing on severe sepsis and septic shock
- Adult and paediatric asthma and consultant sign off
- The British Thoracic Society (BTS) in conjunction with the Royal College of Physicians, undertook audits on adult asthma, smoking cessation and paediatric pneumonia

National audit published reports

To date HQIP (Healthcare Quality Improvement Partnership) has released 33 reports this financial year. These cover audits that submitted data this year, together with reports from 2014 and 2015, e.g. National COPD Audit programme (chronic obstructive pulmonary disease) – outcomes from the clinical audit of COPD exacerbations admitted to acute units in 2014 – national supplementary report.

Other sources of national audit providers include Intensive Care National Audit & Research Centre (ICNARC) whereby quarterly and annual reports are forwarded directly to the relevant hospital specialties on topics including the national cardiac arrest audit, national intensive care unit audit and the case-mix programme.

Learning

HQIP publishes a schedule at the beginning of each financial year with report publication dates. On report publication, they are sent to the relevant clinical audit lead to signpost them to the audit results and dissemination of the outcomes and learning across their speciality. The outcome of the audits are also shared in.

There are five trust wide audit meetings annually where the clinical audit team encourage discussion of the findings of recent reports. However there is perception from some national audit leads that often the audit subject is too specific to be shared across a wide audience and should be targeted departmentally.

Examples of national audits shared at trust wide audit meetings during the year:

Anaesthetics discussing the findings and instigating action relating to the second patient report of the national emergency laparotomy audit (NELA) at their 16/09/16 and 15/11/16 audit meetings which has led to a formal pre and post op risk scoring system	Integrated Medicine are planning to discuss the findings from the national audit of percutaneous coronary interventions, pacing from the national audit of cardiac rhythm management and COPD outcomes from the COPD audit programme at the April 2017 meeting.	National cardiac arrest audits are discussed at monthly resuscitation group meetings and reported monthly to the mortality board, national cancer audits are shared at their multidisciplinary meetings and operational meetings while the Trauma committee bi monthly meetings share the findings of the Trauma & Audit Research Network (TARN).

Quality improvement priorities for 2017/18

In January the trust undertook a one-month consultation with patients, stakeholder and staff to identify the top three priorities the trust should deliver in 2017/18. These priorities are supported by the quality improvement strategy, our quality indicators, as agreed with the commissioners, and an awareness of issues that affect the quality of patients care and experience. These indicators are:

- To improve our performance; as measured by our inpatient survey, specifically:
    - Patients feeling they are involved in their care and decision-making
    - Delivering on our commitment to treat and care for patients with dignity and respect
    - Improving communication with patients especially with regard to care and treatment

- To improve care for patients whose condition is deteriorating:
    - Implementing care plans for all patients which consider the patient's health and treatment priorities and advanced planning to allow implementation of end of life preferences wherever possible
    - By escalation and use of NEWS activation
    - Communicating well and at the earliest stage possible with patients and family regarding deterioration potential outcomes and patient's care preferences

- To reduce the number of patients experiencing a fall while in hospital

Patient experience improvement priority 2017/18: improve our performance; as measured by our inpatients survey

Target for 2017/18

To improve our performance as measured by our inpatients survey, specifically:

- Patients feeling they are involved in their care and decision-making
- Delivering on our commitment to treat and care for patients with dignity and respect
- Improving communication with patients, especially with regard to care and treatment

Planned improvements for 2017/18

The trust plans to implement the following improvement activities in 2017/18:

- Using patient surveys to benchmark and improve the discharge journey for patients
- Using the current survey, complaints and general feedback mechanisms, understand what are the key issues affecting patient experience
- Ensure all elements of the quality improvement strategy underpin excellent patient experience
- Work with patient council and representatives to provide 360° review of patient experience outcomes and sharing of information
- To link with and learn from other trusts who demonstrate excellent results in patient surveys
- Maternity Services: To maintain the patients feedback on 1:1 care while in labour

How we will monitor and report on our progress

Progress against this improvement priority will be reported monthly to the quality board and quarterly to QCRC.

Measure of success

- An improvement in internal and external patient survey results
- Change in behaviour and feedback will be measured by targeted patient surveys and linking to patient gatekeeping organisations.

Patient safety priority 2017/18: to improve care for patients whose condition is deteriorating

Target for 2017/18

To improve care for patients whose condition is deteriorating:

- By escalation and use of NEWS (national early warning score) activation, including to end of life team
- Communicating with patients and family regarding deterioration and outcomes
- Planned improvements for 2017/18

Planned improvements for 2017/18

The trust plans to implement the following improvement activities in 2017/18:

- Undertake technical and awareness training for identifying deteriorating patients
- Ensure all staff understand their responsibilities in escalating deteriorating patients
- Ensure deteriorating patients are reviewed and best-interest decisions taken in consultation with the patient and family
- Use monthly audits to highlight key areas and themes that should have targeted improvements

How we will monitor and report on our progress

In addition to the regular mortality peer review, the trust will audit monthly, those patients who have died with a 'failure to escalate' flag and report to the mortality board and quality board.

Measure of success

- A reduction in complaints, where relatives have been unaware of the deterioration in the patient (resulting in them being unable to attend before the patient dies).
- A reduction in the number of patients undergoing resuscitation intervention which is not in their best interests or within the patient's preferred treatment pathway.
- Trust wide roll-out of 'point of care' (nursing technology fund) using electronic recording of observations with alerts that automatically alarm

Patient safety improvement priority 2017/18: reduce the number of patients experiencing a fall while in hospital

Target for 2017/18

Reduce the number of patients experiencing a fall with harm while in hospital

Planned improvements for 2017/18

The trust plans to implement the following improvement activities in 2017/18:

- Older people should be observed and tested for balance and gait deficits.
- Falls assessment tools will be reviewed across all settings to ensure that they reflect current NICE guidance 161.
- Patients admitted, who have previously fallen, combined with a condition that affects their cognitive ability or physical movement, appear to be at higher risk of suffering a consequence of severe harm and therefore should be prioritised in terms of cohort nursing or 1-2-1 special nursing.
- Patients who have fallen within the last year should be offered intentional rounding (where nurses carry out regular checks at set intervals on patients to ensure their fundamental care needs are met), 1-2-1 nursing, or cohort nursing, to ensure their needs are met.
- The trust will establish a multi-professional 'falls steering group' which will work with partners across the healthcare system to oversee the implementation of a falls-reduction action plan.

How we will monitor and report on our progress

Progress against this improvement priority will be reported monthly to the quality board.

Measure of success

- A reduction in patients suffering harm from avoidable falls in hospital

Statements of assurance from the board

Review of services provided by Bedford Hospital NHS Trust

During 2016/17, Bedford Hospital NHS Trust provided 45 relevant health services and sub-contracted 11 relevant health services. A list of all services provided by the trust is located in annex one.

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

The income generated by the relevant health services reviewed in 2016/17 represents 100 percent of the total income generated from the provision of relevant health services by Bedford Hospital NHS Trust for 2016/17.

Participation in 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 the opportunity to benchmark their practice with each other.

During 2016/17, 45 national clinical audits covered relevant health services that Bedford Hospital NHS Trust provides.

During 2016/17 Bedford Hospital NHS Trust participated in 100% (45/45) of national clinical audits.

The national clinical audits that Bedford Hospital NHS Trust was eligible to participate, and for which data collection was completed during 2016/17:

Table two: Bedford Hospital NHS Trust participation in national clinical audits National Audit	Percentage participation/Continuous
Acute coronary syndrome or acute myocardial infarction	Continuous
Adult Asthma (BTS)	72% (18/25) Completed
Asthma (Paediatric and Adult) Care in Emergency Departments (RCEM)	100% (50/50) Completed
Bowel Cancer (NBOCAP)	Continuous
Breast & Cosmetic Implant Registry (BCIR)	Continuous
Cardiac arrhythmia (NICOR)	Continuous
Case mix programme (CMP)	Continuous
Consultant Sign-Off (RCEM)	100% (50/50) Completed
Coronary angioplasty (NICOR adult cardiac interventions audit)	Continuous
Diabetes (paediatric) (NPDA)	Continuous
Elective surgery (national PROMS programme)	Continuous
Endoscopy audits (38 topics)	Continuous
Endocrine and thyroid national audit (BAETS)	Continuous
Falls and Fragility Fractures Audit Programme (RCP) Fracture Liaison Database	 Continuous

Inpatient Falls National Hip Fracture Database	Continuous Continuous
Head and neck oncology (DAHNO)	Continuous
Inflammatory bowel disease audit	Continuous
Learning disabilities mortality review programme (LeDeR)	Continuous
Major trauma audit (Trauma Audit & Research Network)	Continuous
Maternal, new-born & infant clinical outcome review programme (MBBRACE)	Continuous
National audit of Dementia	100% (50/50) Completed
National cardiac arrest audit (NCAA)	Continuous
National chronic obstructive pulmonary disease audit programme – pulmonary rehab	In progress
National chronic obstructive pulmonary disease audit programme - (BTS)	Continuous
National comparative audit of blood transfusion programme: blood management in scheduled surgery use of blood in haematology	 In progress In progress
NDA National diabetes audit	Continuous
NADIA National diabetes inpatient audit	Continuous
National pregnancy in diabetes audit	Continuous
National diabetes foot care audit	Continuous
National emergency laparotomy audit	Continuous
National heart failure audit	Continuous
National joint registry (NJR)	Continuous
National lung cancer audit (NLCA)	Continuous
National paediatric pneumonia (BTS)	In progress (Data Collection ends 30th April 2017)
National prostate cancer audit	Continuous
National vascular registry	Continuous
Neonatal and intensive special care (NNAP)	Continuous
Oesophago-gastric cancer (NAOGC)	Continuous

Percutaneous nephrolithotomy (PCNL) audit	Continuous
Sentinel stroke national audit programme (SSNAP)	Continuous
Severe Sepsis and Septic Shock (RCEM)	100% (50/50) Completed
Smoking Cessation (BTS)	98% (98/100) Completed
Stress urinary incontinence audit	Continuous

In 2015/16 Bedford Hospital NHS Trust did not participate in one national audit for the following specific reason, identified in Table three.

Table three: Bedford Hospital NHS Trust non-participation in national clinical audits

National Audit	Reason
Community acquired pneumonia audit (BTS	Lack of resources

Table two: national clinical audit reports received during 2016/17 with action taken/planned

National Audit	Actions
British Thoracic Society Emergency Oxygen Audit Report (BTS) (15 August – 1 November 2015)	Discussed at 15/06/16 Integrated Medicine Audit meeting Training being provided for medical and nursing staff on oxygen prescribing and the reaching and recording of patient target saturations at induction, drop-in sessions and online.
National Audit of Percutaneous Coronary Interventions (January to December 2014)	To be discussed at 13/04/17 Integrated Medicine Audit meeting
Trauma & Audit Research Network (TARN)	Trauma Committee 11/05/16 (bi-monthly meetings)
National Cardiac Arrest Audit 2015/16 (NCAA)	Discussed at monthly Resuscitation Committee meetings Information monitored and reported monthly to Mortality Group, Quality Board and included in divisional quality packs
Procedural Sedation in Adults Clinical Audit 2015/16 (RCEM)	Awaiting discussion
VTE Risk in Lower Limb Immobilisation in Plaster Cast	Awaiting discussion

Clinical Audit 2015-16	
Vital Signs in Children Clinical Audit 2015-16	Awaiting discussion
National Oesophago-Gastric Cancer Audit 2016	Under discussion To discuss at May 2017 operational service meeting
National Audit of Cardiac Rhythm Management Devices (2014/15)	To be discussed at 13/04/17 Integrated Medicine Audit meeting
National Diabetes Inpatient Audit 2015	Awaiting discussion
National Heart Failure Audit (2014/15)	Discussed at December Cardiology Audit meeting No action required
National Cancer Patient Experience Survey (2015)	Integrated Medicine Divisional Quality Group meeting 11/08/16 Cancer Management meeting 25/08/16 Bedford Cancer Action meeting September 2016 Wards to extend safety huddle and establish communication questions between Nurses and patients for that day. Macmillan GP Liaison to discuss with GP colleagues and discharge summaries are transferred electronically to GP's. Staff to ensure that patients are referred to pain team or palliative care team in a timely manner. PCA training on wards have been completed and a recent inpatient survey has also taken place on pain relief.
National clinical audit of biological therapies UK inflammatory bowel disease (IBD) audit	Discussed at 15/11/16 Integrated Medicine Audit meeting Awaiting action plan
Sentinel Stroke National Audit Programme (SSNAP	Awaiting lead for topic & discussion

Acute organisational audit report 2016	
BTS Smoking Cessation Audit Report – Smoking Cessation Policy & Practice in NHS Hospitals (1 April – 31 May 2016)	Report circulated, awaiting confirmation of shared learning
National Lung Cancer Audit Annual Report 2016	Awaiting discussion at operational service meeting March/April 2017
Myocardial Ischaemia National Audit Project report 2014/15	To be discussed at 13/04/17 Integrated Medicine Audit meeting
National Diabetes Audit, 2015-2016: Report 1: Care Processes and Treatment Targets, England and Wales Learning Disability - Supplementary Information	Report circulated, awaiting confirmation of shared learning
COPD: Who cares when it matters most: National COPD Audit programme - Outcomes from the clinical audit of COPD exacerbations admitted to acute units in 2014 - National supplementary report & Results and Data analysis	Report circulated, awaiting confirmation of shared learning
National Audit of Cardiac Rhythm Management Devices (2015/16)	To be discussed at 13/04/17 Integrated Medicine Audit meeting
National Pregnancy in Diabetes 2015	Report circulated, awaiting confirmation of shared learning
• ICNARC (Intensive care national audit and research centre) Case mix programme:	• Discussed at departmental meetings
The Second Patient Report of the National Emergency Laparotomy Audit (NELA) December 2014 to November 2015	Discussed at 16/09/16 & 15/11/16 Anaesthetics Audit meetings All emergency laparotomies should have a formal pre and post-operative risk score High risk patients should have active consultant input intra-operatively and be admitted to critical care

National Comparative Audit of Lower Gastrointestinal Bleeding and the Use of Blood	Awaiting discussion
Treat the Cause: A review of the quality of care provided to patients treated for acute pancreatitis A report published by the National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Awaiting discussion
National Vascular Registry 2016 Annual Report	Awaiting discussion
National Prostate Cancer Audit - Third Year Annual Report - 2016	Awaiting discussion at operational service meeting March/April 2017
National Bowel Cancer Audit Annual Report 2016	Awaiting discussion at operational service meeting March/April 2017
National Joint Registry 13th Annual Report (NJR)	Awaiting discussion
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE -UK)	Awaiting discussion
National Paediatric Diabetes Audit Report 2014-15 Part 1: Care Processes and Outcomes	Discussed at 15/11/16 Paediatrics Audit meeting Clinical Psychologist to see all newly diagnosed diabetic patients Patient/parents must sign a pump contract before this is agreed and funded Education to be offered for different age groups focusing particularly on patients transitioning from primary to secondary or middle school
BTS Paediatric Asthma report 1-30 November 2015	To be discussed at 24/01/17 Paediatrics Audit meeting
National Paediatric Diabetes Audit Report 2015-2016	To be discussed at 13/04/17 Paediatrics Audit meeting

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 accreditation incorporating the endoscopy global rating scale requirements.

Local audit

The reports of 76 local clinical audits were reviewed by Bedford Hospital NHS Trust in 2016/17 and the trust intends to take the following actions to improve the quality of healthcare provided:

Table three: local clinical audits and associated actions

Local clinical audit	Actions
Integrated medicine	
Emergency medicine	
Investigation and Management of Acutely Delirious Patients	Teaching sessions to be provided to AAU staff covering required investigations and management in cases of delirium, specifically targeting blood cultures and use of haloperidol
Respiratory	
EBUS Referral Audit (Endobronchial Ultrasound Guided Needle Aspiration)	Results to be disseminated to the management team and other respiratory team members EBUS service to start
Acute Respiratory Assessment Service (ARAS)	Liaising with the Estates Department to introduce additional and improved signage to the ARAS room
Early Supported Discharge Scheme (ESD)	Improve referral to pulmonary rehab, inhaler technique and offering PHP by implementing a respiratory discharge bundle to address the following: Inhaler technique Offering PR Offering PHP Improve patients understanding of lung condition by reviewing and delivering a lung anatomy talk at rehabilitation Improve referral to physio technicians by referring all patients discharged from ESD to the technicians Re-audit in October 2017
Home Oxygen Service	Ensure patients are aware of frequency of their review by informing them at each review when they will be seen next No negative feedback was received for this service
Oncology	
Patient satisfaction	Findings discussed at operational meetings between June

questionnaires for: Brain cancer, Breast cancer, Colorectal cancer, Gynaecology cancer, Haematology cancer, Head and Neck cancer, Lung cancer, Skin cancer, Upper GI cancer, Urology cancer, Acute cancer and CUP	and August 2016. Discussed further at October 2016 CMG meeting Patients are routinely offered a copy of their consultation letter and written information provided on treatment and side effects. 3 CNS's now in post and nurses are present in all clinics. Demand during clinics has on occasions caused a delay in nurses being able to get to clinic promptly. Possibility of Breast Oncology CNS post being explored by division. HNA is completed with all relevant patients at the point of diagnosis and during nurse led follow ups. Macmillan E HNA pilot to commence Autumn 2016 CNS's and Consultants routinely provide education sessions to staff on the pathway. Formal presentations also given at junior doctor inductions Work ongoing with L&D to ensure that patients receive a full explanation of their treatment options (L&D and MV) GPs provide leaflets about CXR and CT and radiology provide information on CT guided biopsy. CNS's/Consultants explain bronchoscopy to patients
All specialties	
Endometrial Cancer Histopathology Reporting	To continue to type and provide a FIGO grade in the surgical reports of all the endometrial cancers diagnosed on pipelle endometrial biopsies. This is vital to determine the need for full surgical staging and whether the operation takes place in a cancer unit or cancer centre. To remain compliant with the Royal College minimum dataset guidelines. Pathology peer review verifies and improves the accuracy and quality of pathology diagnoses and interpretations, and thereby appropriately reflecting the pathology data.
Compliance with Core Data Items in the Royal College of Pathology Dataset for Malignant Melanoma Reporting	Circulate this audit to all pathologists within Bedford Cellular Pathology Department. Following discussion with all consultant colleagues, introduce a standardised proforma for melanoma reporting. Re-audit in 2018 the reports produced in 2017, i.e. following the introduction of standardised proforma reporting.
Rectal MRI Audit	Continue use of standardised template reporting to meet RCR standards To "double report" in difficult cases

	To update/attend courses to improve reporting standards Re-audit in 2018
Appropriateness for Blood Component Requests, Usage and Wastage	The Surgical bleeding guide in the Transfusion Policy is not currently being followed. Most surgery can have a Group & Save. With the introduction of the 2 patient sample blood can be issued electronically in 15 minutes The Trust Transfusion Policy states that platelets need to be reviewed by a consultant haematologist, this is working well, and recommend this continues The Trust Transfusion policy has triggers for giving RBC asymptomatic Hb<70 and Hb<80 symptomatic. These do not seem to be followed. The recommendation are from Patient Blood management, NICE 24 Blood Transfusion (Nov 2015), Joint United Kingdom (UK) Blood Transfusion and Tissue Transplantation Services Professional Advisory Committee, suggest a restrictive regime In conventional meta-analyses restrictive transfusion strategies compared with liberal transfusion strategies were associated with a:- reduction in the number of red blood cells used and the number of patients being transfused but were not associated with benefit or harm regarding mortality Do not transfuse asymptomatic non-bleeding patients whose HB is > 70g/L. Serious Hazards of Transfusion 2013 recommend that 1 RBC is given and then reviewed (Berger et al 2012)
Planned Care	
Anaesthetics	
Pain Management after Day Surgery	Present findings to Recovery staff Pain Scale teaching for Recovery staff by Pain Nurse Specialist Introduce use of IV Fentanyl for Recovery use in Day Surgery cases Re-audit in 2018
Preoperative and Requirement of Blood Transfusion in Patients Undergoing Lower Limb Joint Replacements	Develop and implement a Patient Blood Management programme by August 2017 Senior management of Planned Care aware and also agreed for a Lead Person to lead on patient blood management project
Trauma and orthopaedics	

Management of Intra-Articular Distal Radius Fractures	Teaching session for A&E and orthopaedic team on intra-articular distal radius fractures to ensure prompt referral and expedite fracture clinic appointments Ensure adequate equipment is available in theatres for operative management of fractures Re-audit in 3 months after teaching session to monitor progress
Surgical Procedures in Fracture Neck of Femur (NOF)	Implement a Protocol regarding surgical treatment of fractured neck of femurs (NOF) in accordance with NICE guidelines to increase compliance, improve care, rehabilitation and financial savings.
Timing of Surgery in Fracture Neck of Femur	Each action should:- Planned trauma theatre over weekend Availability of theatre supporting staff for theatres that over run in weekdays
Obstetrics and gynaecology	
Neonatal Abstinence Scoring and Maternal use of SSRI	Repeat audit with a larger sample size in order to draw a more robust conclusion Review of literature around scoring system for SSRI in revised Finnegan scoring Discussion with the neonatal team regarding the length of stay for NAS scoring.
GAP (growth assessment protocol)	To look into whether gestation related optimal weight training can be linked to the trust's mandatory training record, WIRED GAP project team established Continuous monthly audits
Reduced Foetal Movements	Women to be provided with leaflets regarding reduced fetal movements from 16 weeks Women to be explained what "pattern of fetal movements is" Detect Intrauterine Growth Restriction (IUGR) and reduced fetal movements Detect other co-morbidities for example or including smoking and reduced fetal movements Perform a prospective study
Outpatient Cervical Ripening in Low Risk Women	Any fetal/neonatal/maternal mortality or significant morbidity in outpatient IOL patients should have a Datix submitted Re-audit using mentioned standards in 2018 to ensure continuing good practice

• Routine enquiry audit - • maternity services • Bedford Hospital NHS Trust	Monthly audit, monitoring and investigation the by safeguarding team. Safeguarding team to circulate how future enquiries are made and how the re-recording of documentation will serve as a reminder to doctors
Miscarriage audit	Review case notes of patients who had emergency surgery to identify specific risk factors Annual re-audit
Foetal Blood Sampling	Audit to be modified to improve capture of Foetal Blood Sampling Re-audit in 2017
Paediatrics	
• Review of abnormal Echo results	All abnormal echo reports to be copied to cardiac lead All echo reports need to be signed by clinician before filing To ensure administration staff are aware awareness All abnormal echo reports to be discussed with cardiac lead and appropriate follow up to be organised
• ROP screening in newborn babies	Future audits to be based on EPR data collection from Badgernet To audit provision of information leaflet to parents from documentation in nursing notes. To record this on Badgernet if possible
• Opinions of teenagers attending ADHD clinic in CDC	Create a pre-appointment questionnaire either to be sent out with the appointment letter given when they check-in at clinic Ask patients if they would like some appointment time without parents present at the start of the clinic Create a standardised information pack including: Information on ADHD – what it is, what causes it, how it is treated Information about ADHD medication Information about sleep and sleep hygiene A list of useful publications and websites Information about available support groups
Trust wide	
Pain scoring and inpatient satisfaction with pain control	Obstetrics and Gynaecology (O&G) patients now included in audit Regular ongoing education in pain control management to include O&G staff Re-audit annually

Discharge medicines returned to pharmacy audit	*Ward:* Plan for discharge ahead of time and liaise with the ward pharmacist Give To Take Out (TTO) medicines to the ward pharmacist for screening with enough time to allow them to be dispensed before patient discharge Track the progress of the TTO on the online tracking system and contact the ward pharmacist if a delay occurs Contact patients/ their relatives that have gone home without their medicines to inform them that TTO is ready to collect Return items to the pharmacy department on a regular basis, in the correct manner Return fridge items separately and in a fridge bag to ensure that they are identified as fridge items upon receipt *Pharmacy:* Ensure that ward pharmacists continually work with ward staff to ensure they know how to return medicines, particularly fridge items and high cost drugs Ensure that all ward pharmacists prioritise TTO provision and discharge as the trust's priority Ensure that returned items are dealt with immediately on arrival back in Pharmacy, and returned to stock where appropriate Offer a delivery service run by a member of the pharmacy team – will also allow appropriate counselling Introduce a returns team in pharmacy that will deal with the previous day's returns before starting new work for the day Engage with the CCG for community pharmacies to take on discharge medication dispensing. This could also be considered for outpatient dispensing Re-audit
Antimicrobial prescribing point prevalence audit	Antimicrobial guideline review Training of medical and nursing staff in the importance of antimicrobial stewardship Establish an antimicrobial ward round – microbiologist and antibiotic pharmacist review To explore the use of "stop review" date stickers in medical notes Re-audit
Audit of DNACPR for patients with a learning	Continue use of the categories of reason for use of DNACPR Develop clear identification on the form of the need for

disability	mental capacity assessment and best interest decisions Continue delivery of Mental Capacity Act training Re-audit

The reports of four local patient experience surveys were reviewed by Bedford Hospital NHS Trust in 2015/16 and the trust intends to take the following actions to improve the quality of healthcare provided.

Table four: patient experience surveys and associated actions

Local patient experience survey	Actions
Integrated medicine	
Acute respiratory assessment service	On movement of treatment room, estates will review signage to assist patients with locating the clinic Annual survey
Early supported discharge scheme for chronic obstructive pulmonary disease patients	All patients offered a choice of am/pm visits to offer more flexibility Annual survey
Home oxygen service	Findings fed back to Respiratory team Respiratory network Commissioners of home oxygen service BOC Healthcare All patients requesting support have been contacted by the Respiratory nursing team Annual survey
ENT Patient Satisfaction Survey	ENT performed well with the majority of patients happy with the service provided. Patients are now informed of waiting times with an introduction of a white board in the reception area displaying the length of the delay. Delays are considerably less now due to the more manageable twenty minute slots for each appointment.

Monitoring of action

The clinical audit team will be developing processes to receive assurance that audit actions are implemented in a timely fashion.

National confidential enquiries

The national clinical audits and national confidential enquiries that the trust was eligible and participated in, and for which data collection was completed during 2016/17, are listed below. Alongside the audit title are the numbers of cases submitted for each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Table five: Bedford Hospital NHS Trust participation in national confidential enquiries

National confidential enquiry	Percentage participation
Mental Health	100%
Acute pancreatitis	100%
Chronic Neurodisability	Data submitted, study still open and figures have not been finalised by NCEPOD
Young People's Mental Health	Data submitted, study still open and figures have not been finalised by NCEPOD
Cancer in Children, Teens and Young Adults	Data submitted, study still open and figures have not been finalised by NCEPOD

Participation in clinical research

The number of patients receiving health services provided or sub-contracted by the trust in 2016/17, that were recruited during that period to participate in research approved by a research ethics committee was 599. This includes both portfolio and non-portfolio studies. In addition to the above there are 282 patients in the follow up process.

Participation in clinical research demonstrates the trust's commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff stay informed of the latest possible treatment possibilities and active participation in research leads to successful patient outcomes.

The trust was involved in conducting 33 clinical research studies in 2016/17 including the following areas oncology, ophthalmology, cardiology, haematology, dermatology, surgery, midwifery, paediatrics and respiratory medicine.

There were over 40 clinical staff participating in research approved by a research ethics committee at the trust during 2016/17. These staff participated in research covering 10 medical specialties.

In the last three years, 90 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.

Commissioning for Quality and Innovation (CQUIN) framework

A proportion of Bedford Hospital NHS Trust's income in 2016/17 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. Further details of the agreed goals for 2016/17 and for the following 12 month period are available online at:

https://www.innovation.nhs.uk/pg/cv_blog/content/view/40573/network

In 2016/17 six CQUINs applied to the trust (listed in table six).

Three of the six were mandated nationally:

- Health and wellbeing
- Sepsis
- Antimicrobial

The remaining three were negotiated locally with Bedfordshire Clinical Commissioning Group:

- Cancer waits
- High resource patients
- Reducing care home admissions

Table six: Bedford Hospital NHS Trust achievement against 2015/16 CQUINs

Indicator identifier	Description	Overall achievement of target (%) for 2015/16
1a	Health and wellbeing	NOT AVAILABLE UNTIL 7 MAY
1b	Healthy Food	
1c	Flu Vaccine	
2a	Sepsis in ED	
2b	Screening	
2c	Sepsis inpatients	
2d	Screening	
3a	Antimicrobial Resistance	
3b	Antimicrobial Stewardship	

Indicator identifier	Description	Overall achievement of target (%) for 2015/16
4a	Cancer 62 day waits	NOT AVAILABLE UNTIL 7 MAY
4b	RCAs on >104 days	
5	High resource patients	
6	Reducing care home admissions	

Care Quality Commission registration and compliance

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

The trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

Following inspection by the CQC in December 2015 (and outcome report published in April 2016), the trust developed an action plan to deliver the recommendations arising from the inspections and to further advance the quality improvement strategy.

The outcome of the inspection was the trust was rated as requires improvement and the overall rating grid is shown in table seven

	Safe	Effective	Caring	Responsive	Well-Led	Overall
Urgent & Emergency Services	Requires Improvement	Good	Good	Good	Good	Good
Medical Care	Good	Good	Good	Good	Good	Good
Surgery	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Critical Care	Good	Good	Good	Requires Improvement	Good	Good
Maternity & Gynaecology	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement	Requires Improvement
Children & Young People	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement
End of Life Care	Good	Requires Improvement	Good	Good	Good	Good
Outpatients & Diagnostic Imaging	Requires Improvement	Inspected but not rated	Good	Good	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	**Requires Improvement**

The action plan underpinned the four Requirement Notices from the CQC and the trust delivered on these actions by December 2016. The requirement notices related to:

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

- Staffing: ensure safe staffing in the paediatric assessment unit

Actions taken to deliver on the inspection outcomes provided an opportunity to reflect and develop systems and processes to enhance quality of care and which included:

- Privacy and dignity (enter and view) inspection by Healthwatch Bedford
- New privacy area (pod) for streaming in A&E
- Increased in the number of staff trained in safeguarding
- Implemented a chaperone policy
- Introduction of trust-wide learning newsletter supported by divisional and speciality bulletins
- Leaflets translated into common languages of Bedford residents
- New DNACPR/TEP form implementation and audited
- Maternity external review progress leading to the development of a transformation board and a dashboard to provide oversight on key standards for patient safety and experience

Assurance

The quality improvement monitoring group has now evolved into the CQC steering group, with formal minutes, action log and exception reports and meets on a monthly basis. Regular mock inspections across all departments and divisions have been implemented since November 2016 monitoring improvements and compliance.

- Outcomes of mock inspections are fed back to ward/service managers and matrons and where there are specific themes, these are monitored by clinical governance.
- Regular confirm and challenge meetings have been held with clinical leaders and the director of nursing. Each service that received a rating of requires improvement, was a priority followed by other services. This was to establish preparedness and triangulation of information, complaints, audit, serious incidents, guidelines and risk registers.
- This has provided assurance that improvements have been made and sustained and , where risks remain that they are recorded on the trust risk register with appropriate mitigation. Supporting the internal reviews, the trust's internal auditors reviewed and assessed the trust in delivering the action plan and readiness for future inspections and rated the trust 'amber/green' with reasonable assurance.

Next steps

- The CQC has consulted on the next phase of regulation; a more targeted, responsive and collaborative approach. The trust has responded to this consultation.
- To support our internal mock inspections, the trust is planning to invite external bodies, such as royal colleges, professional organisations, to assure the trust on its level of preparedness

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.

To ensure the trust is consistently compliant with its duty, quarterly audits are under taken. Duty of candour compliance is also a key quality metric on the trust's quality scored and compliance is monitored monthly. Compliance with duty of candour requirements also forms part of the trust's monthly quality performance report to the Bedfordshire Clinical Commissioning Group.

Learning from openness

When responding to complaints the principles of duty of candour are complied with, the response letters from the chief executive are open and transparent and include an apology where necessary. The trust encourages those involved in claims to observe duty of candour requirements, and the standard letter to clinicians informing them of claims, which have not previously been considered as incidents or complaints, asks if the clinician has observed the requirement.

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

Sign Up To Safety

The trust joined the national Sign up to Safety campaign in July 2015. The trust's targets against the campaign pledges are detailed below:

Pledge one: put safety first. Commit to reduce avoidable harm in the NHS by half 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
- ✓ Increase 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
- ✓ Sustain low levels of clostridium difficile
- ✓ Reduce the number of cardiac arrests by 20 percent
- ✓ Reduce numbers of category two pressure ulcers by 20 percent per 1000 bed days
- ✓ Reduce category three pressure ulcers by 20 percent per 1000 bed days
- ✓ Reduce the numbers of patients who suffer harm from falls by 20 percent
- ✓ 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
- ✓ Patients report an increased satisfaction in being treated with dignity
- ✓ Each ward/ department will have an identified dignity champion, as a resource for staff, patients and relatives
- ✓ 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
- ✓ 95 percent of staff have an appraisal in which goals are aligned with the trust's vision and values
- ✓ 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

- ✓ Recommendations from Freedom to Speak Up are implemented in order to create an honest and open reporting culture
- ✓ There are 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
- ✓ Continue to invite partners to participate in internal compliance reviews
- ✓ Support patients and carers in delivering self-care to reduce harm from pressure ulcers
- ✓ Continue to implement duty of candour requirements and review our approach to support staff to ensure that implementation is effective
- ✓ Work with key stakeholders to support internal and external surveillance of our performance on patient safety and quality
- ✓ Listen to and engage with staff and patients through patient feedback sources such as listening events
- ✓ Carry out root cause analysis investigations where serious incidents occur and share these with the patient and/or their carers
- ✓ Offer 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
- ✓ Develop and implement a programme an awareness and training programme with staff and patients awareness of mental health first aid and develop a programme for
- ✓ Keep the patient voice at the forefront of our business by ensuring a patient story is heard at the trust board meeting every month
- ✓ Continue 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 improved understanding of measuring and monitoring safety and it will continue the collaborative and work with commissioners and local community healthcare to reduce harm from pressure ulcers and supporting complex and 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 partner 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 change in cultural. 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
- ✓ Ensure on-going improvement in the quality and safety of patient care through the clinical quality strategy
- ✓ Ensure staff understand their responsibilities for patient safety through the trust's core values framework
- ✓ Continue to deliver root cause analysis investigation training to middle and senior managers
- ✓ Continue a programme of incident investigation and risk management to all department and front-line managers
- ✓ Routinely monitor the quality of care being provided across all services
- ✓ Challenge poor performance or variation in quality
- ✓ Incentivise and reward high quality care and quality improvement through promotion of vision and values, staff awards and listening events and roadshows

Data quality

Bedford Hospital NHS Trust submitted records during 2016/17 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:

- 99.83 percent for admitted patient care;
- 99.92 percent for outpatient care; and
- 98.73 percent for accident and emergency care.

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

- 100% percent for admitted patient care;
- 100% percent for outpatient care; and
- 99.98 percent for accident and emergency care.

Information governance toolkit

Bedford Hospital NHS Trust's information governance assessment report overall score for 2016/17 was 73 percent and was graded green (achieved attainment level two or above) on all requirements.

Clinical coding accuracy

Bedford Hospital NHS Trust was not subject to the payment by results clinical coding audit during the reporting period by the Audit Commission.

IGT clinical coding audit undertaken in March 2017 attained a level three for requirements 505 and 510. This is an improvement on last year with a primary diagnosis accuracy score of 95.5%

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

- Education and training for junior doctors
- Feedback and sharing of coded data for clinician
- Continue the data quality training workshops for all staff

Part three: overview of the quality of our care in 2016/17

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

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

Figure eight: the five Domains of the NHS Outcomes Framework

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 for episodes of ill health or following injury	
Domain four	Ensuring that people have a positive experience of care	Patient experience
Domain five	Treating and caring for people in a safe environment and protecting them from avoidable harm	Safety

Our performance against 2015/16 quality indicators

Eight quality account indicators apply to Bedford Hospital NHS Trust in 2016/17:

- 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 1,000 bed days
- Rate of patient safety incidents and the percentage resulting in severe harm or death

Summary Hospital-Level Mortality Indicator (SHMI)

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).

The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.

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

Table nine

	2014/15	2015/16	2016/17
Bedford Hospital NHS Trust	108.7 Band two 'As expected' 23.0% Palliative care	0.989 Band two 'As expected' 27.4% Palliative care	1.033 Band two As expected Not available
England average	100.00	100.00	100.00
Best performing Trust	59.7 Band three 'Lower than expected' 0% Palliative care	0.652 Band three 'Lower than expected' 0.2% Palliative care	0.690 Band three Lower than expected Not available
Worst performing Trust	119.8 Band one 'Higher than expected' 32.2% Palliative care	1.177 Band one 'Higher than expected' 29.6% Palliative care	1.164 Band one Higher than expected Not available

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

Notes:

- 2014/15 data = October 2013 to September 2014 (published April 2015)
- 2015/16 data = October 2014 to September 2015 (published March 2016)
- 2016/17 data = October 2015 to September 2016 (published March 2017)

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

- The trust continues to improve its SHMI

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

- Using the electronic mortality module on Datix to analyse mortality data
- Continued review of mortality indices via the mortality review board in conjunction with CHKS data analysts
- Commission reviews of outliers diagnostic groups
- Individual review of NCEPOD ‘E’ deaths

Patient Reported Outcome Measures (PROMs)

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.

	2014/15	2015/16	2016/17
Bedford Hospital NHS Trust	0.069	0.078	0.084
England average	0.084	0.088	Awaiting publication
Best performing Trust	0.154	0.135	Awaiting publication
Worst performing Trust	0.000	0.008	Awaiting publication

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)

- 2014/15 - data (published February 2015) for period April 2014 to December 2014
- 2015/16 - data (published February 2016) for period April 2015 to September 2015

- 2016/17 - provisional data (published February 2017) for period April 2016 to September 2016

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

- Although the trust's score improved in 2016/17 it recognises the need to increase the rate of return of PROMs questionnaires to ensure the data represents as many patients as possible

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 2016/17 data to understand what improvements need to be made.

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.

	2014/15	2015/16	2016/17
Bedford Hospital NHS Trust	6.06	-0.021	Awaiting publication
England average	-8.25	8.99	Awaiting publication
Best performing Trust	14.39	13.14	Awaiting publication
Worst performing Trust	5.59	4.26	Awaiting publication

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)

- 2014/15 - data (published February 2015) for period April 2014 to December 2014
- 2015/16 - data (published February 2016) for period April 2015 to September 2015
- 2016/17 –no data available for the reporting period

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

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 2016/17 data to understand what improvements need to be made.

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.

	2014/15	2015/16	2016/17
Bedford Hospital NHS Trust	21.56	0.306	0.439
England average	21.44	22.09	Awaiting publication
Best performing Trust	22.95	24.61	Awaiting publication
Worst performing Trust	16.29	18.13	Awaiting publication

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

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

- 2014/15 - data (published February 2016) for period April 2014 to December 2014
- 2015/16 - data (published February 2016) for period April 2015 to September 2015
- 2016/17 - provisional data (published February 2016) for period April 2015 to September 2015

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

- The trust received provisional receive PROM score for varicose vein 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 2016/17 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.

	2014/15	2015/16	2016/17
Bedford Hospital NHS Trust	14.40	No score	Awaiting publication
England average	16.14	16.79	Awaiting publication
Best performing Trust	18.48	19.34	Awaiting publication
Worst performing Trust	11.48	12.40	Awaiting publication

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

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

- 2014/15 - data (published February 2016) for period April 2014 to December 2014
- 2015/16 – provisional data (published February 2016) for period April 2015 to September 2015
- 2016/17 – no data available for the reporting period

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

- The trust did not receive PROM score for knee replacement surgery between April 2015 and September 2015 because there were too few records to model (10 records)

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 2016/17 data to understand what improvements need to be made.

Emergency readmissions to the hospital within 28 days of discharge

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.

	2014/15	2015/16	2016/17
0 to 15 years of age	6.9%	8.5%	9.19%
16 years and over	10.3%	10.7%	7.4%

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

Notes:

- 2014/15 - data provided via CHKS source – admitted patient care dataset
- 2015/16 - data provided via CHKS source – admitted patient care dataset
- 2016/17 - 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 awaits the official publication of 2014/15, 2015/16 and 2016/17 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 awaits the publication of official 20116/17 data to understand what improvements need to be made.

Responsiveness to the personal needs of patients

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

	2014/15	2015/16	2016/17
Bedford Hospital NHS Trust	73.3%	63.7%	Awaiting publication
National average	76.6%	64.4%	Awaiting publication
Best performing trust	87.4%	78.6%	Awaiting publication
Worst performing trust	67.4%	51.9%	Awaiting publication

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

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

- Data for 2016/17 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 2016/17 to understand where to focus its improvements.

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

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.

	2014/15	2015/16	2016/17
Bedford Hospital NHS Trust	75%	78%	72%
England average	67%	69%	70%
Best performing Trust	89%	89%	85%
Worst performing Trust	38%	46%	49%

Source: Picker Institute Staff Survey (http://www.nhsstaffsurveys.com/Page/1006/Latest-Results/2014-Results/)

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

- The trust has a lower score in 2016 (when compared to both 2014 and 2015) but is still above the national average.

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 are currently taking place until the end of April into early May to develop an engagement and improvement plan based on staff feedback. These listening events will continue during the year as a permanent engagement cycle of meetings.

Percentage of admitted patients who were risk assessed for venous thromboembolism

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.

	2014/15	2015/16	2016/17
Bedford Hospital NHS Trust	95.19%	95.64%	97.64%
England average	95.99%	95.75%	Awaiting publication
Best performing trust	100%	100%	Awaiting publication
Worst performing trust	88.46%	75.15%	Awaiting publication

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

2016/17 - 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 VTE committee.

Rate of Clostridium difficile infections

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 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.

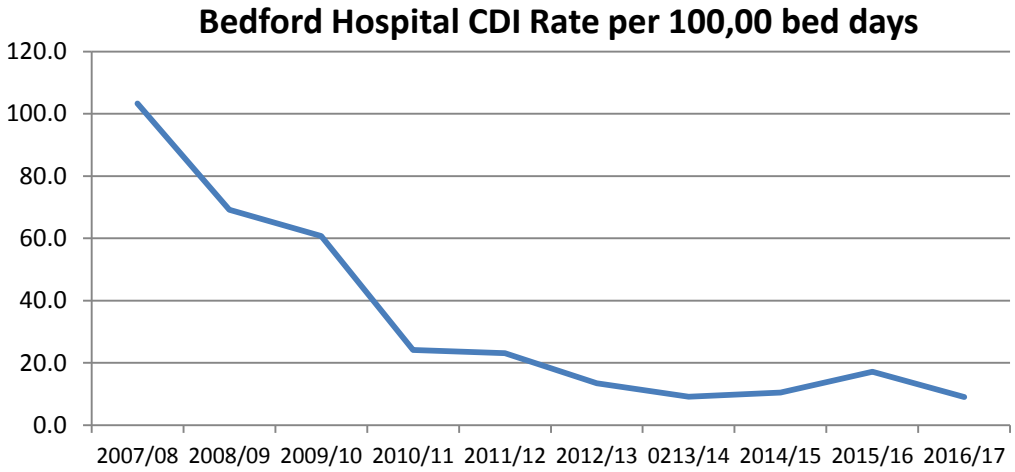
The following cases are excluded from the indicator:

- 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).

	2014/15	2015/16	2016/17
Bedford Hospital NHS Trust	10.9	17.8	9.0 prov*
England average	15.1	14.9	Awaiting publication
Best performing Trust	0	0	Awaiting publication
Worst performing Trust	62.2	66.0	Awaiting publication

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

* data for 2016/17 (11months) = incomplete internal figures based on 11 reported cases / 122,243 bed days up to 28th February 2017



As last year, Bedfordshire Clinical Commissioning Group (BCCG) have set the trust a ceiling trajectory of 10 hospital apportioned cases of laboratory confirmed (GDH positive and toxin positive) cases of clostridium difficile. To date the trust has been apportioned 11 cases, of which three have been successfully appealed and a further two are awaiting appeal. In all cases there is no evidence to suggest cross infection between patients has occurred, as the ribotyping is different for each specimen and following a root cause analysis of each case, all cases were designated as being unavoidable and no lapses in care were identified.

Bedford Hospital NHS Trust has continued to implement the actions identified last year, which were:

- Prompt identification and escalation of patients with potential symptoms or at risk of other harms
- Prompt escalation of patient with diarrhoea to the infection prevention and control team
- Prompt isolation of patients on request
- Prompt specimen collection from the patient
- Implementation of safety huddles to improve communication of information
- E-prescribing to enable 14 day course treatment for C. difficile

Building on the implementation of last year's interventions, additional actions have been taken to improve the rate, and so the quality of its services, these are:

- Participated with NHSi in an, "IPC Collaborative: 90 Day Improvement Programme" (a cohort of 39 NHS trusts), which resulted in a revised bowel habit recording tool (stool chart) and associated education.
- Implementing an infection prevention and control admission risk assessment form.
- Revised Infection, Prevention and Control (IPC) education, both curriculum and varied delivery methods, taking account of new technologies.
- A review and change in the cleaning / decontamination policy and schedule – a rationalisation.
- A review and change of the cleaning / decontamination products used in the Trust.
- Producing an operational procedure for "Cleaning and Disinfecting Medical Patient Equipment (Medical Devices)".

- Implementing a “Patient medical device / equipment cleaning / disinfection audit tool”, undertaken monthly by Matrons / Ward Managers.
- Developed a Patient Specialist Care Plan for the, “Management of Patients with Acute clostridium difficile Infection”.
- Weekly multidisciplinary clostridium difficile ward round, reviewing each symptomatic case.
- Review of antibiotics that are highly associated with predisposing to clostridium difficile infection and advising treatment regimens that are effective but less likely to induce a clostridium difficile infection (antibiotic stewardship).

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

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.

Number of patient safety incidents per 1000 bed days

	2014/15*	2015/16**	2016/17***
Bedford Hospital NHS Trust	34.21 incidents	36.2 incidents	38.2 incidents
National average	35.9 incidents	39.3 incidents	Not available
Best performing trust	0.24 incidents	18.1 incidents	Not available
Worst performing trust	74.9 incidents	74.8 incidents	Not available

Percent of patient safety incidents resulting in severe harm

	2014/15**	2015/16***	2016/17***
Bedford Hospital NHS Trust	0.32%	1.2%	0.7%
National average	0.39%	0.35%	Not available
Best performing trust	0%	0.017%	Not available
Worst performing trust	2.3%	2.9%	Not available

Percent of patient safety incidents resulting in death

	2014/15**	2015/16***	2016/17***
Bedford Hospital NHS Trust	0.5%	0.59%	0.2%
National average	0.11%	0.12%	Not available
Best performing trust	0%	0%	Not available
Worst performing trust	0.8%	0.72%	Not available

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

- The trust's performance is an improvement on the previous year and will benchmark itself once national data is published.

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

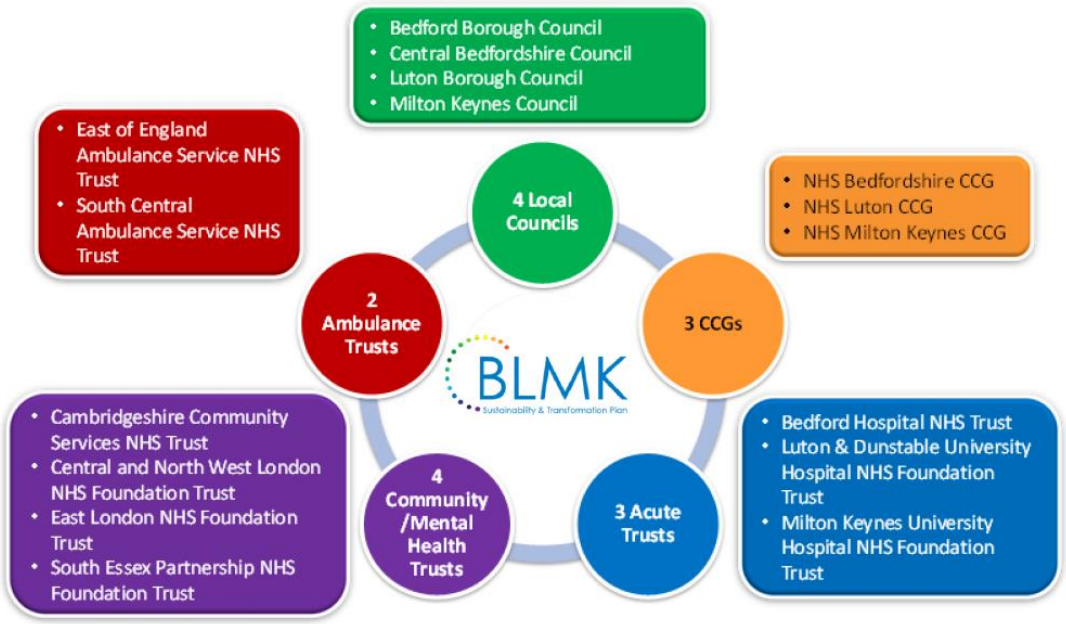
- The trust will continue to review patient deaths through its mortality review group
- Patient safety incidents continue to be uploaded to the NRLS on a weekly basis.
- Incidents resulting in moderate, severe harm and death are validated on a weekly basis through the Datix group meetings and prior to uploading of the data to the NRLS.
- The trust's governance work steam to improve learning from incidents, never events and complaints

Summary of 2016/17

Bedfordshire, Luton and Milton Keynes (BLMK) Sustainability and Transformation Plan (STP)

In spring 2016, 16 health and social care partners came together to form the Bedfordshire, Luton and Milton Keynes (BLMK) Sustainability and Transformation Plan (STP). The aim of the STP is to support delivery of the 'triple aim' of the NHS 5 year Forward View – improved heah and wellbeing, transforming quality of care and financial sustainability.

The 16 BLMK STP partners



Locally the STP has developed five priority areas which were set out in the initial plan submitted to NHS England in November 2016:

- Prevention
- Primary, community and social care
- Secondary care
- Digital programme
- System Redesign

Bedford Hospital is well engaged within the programme, in particular in Priority 3. Public engagement events have been held in January and March 2017 and there is a series of staff communication events taking place throughout March 2017 which culminate in the creation of a Staff Voice Partnership, which will bring together staff from all the partner organisations.

Priority 3 has grouped hospital services into six areas of focus:

- Emergency Care
- Planned Care
- Centres of Excellence
- Care Closer to home
- Maternity Care
- Paediatrics

The thinking on potential hospital models in these areas is expected to emerge in spring 2017, with public consultation later in 2017 / early 2018.

The trust believes the STP offers a real opportunity to support the delivery of its Clinical Strategy (developed in 2014) and in particular its aims of integration with community services and with other acute and specialist providers through clinical networks and pathways. The geography of the STP provides for a stronger planning footprint that had not previously been exploited and will support the development of more sustainable services without the need for significant service reconfiguration.

Serious Incidents – reducing patient harm

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 2015).

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 root causes of the incident, lessons learnt and action plans to prevent recurrence of the incident, within 60 days.

Serious incidents declared in 2016/17

During the financial year 2016/17, the trust declared a total of 37 Serious Incidents compared with 55 in 2015/16. A monthly breakdown of Serious Incidents is provided.

Table 1: Serious Incidents by Month 2015/16

Month	Number of Serious Incidents
April 2016	2
May 2016	7
June 2016	7
July 2016	4
August 2016	3
September 2016	3
October 2016	2
November 2016	3
December 2016	3
January 2017	2
February 2017	1
March 2017	0 (to date)
Total 2016.17	37

A breakdown of the categories of Serious Incidents that occurred in 2016/17 is presented in.

Type of incident	Number of Serious incidents
Falls resulting in serious injury	10
Diagnostic incident including delay	7
Drug Incident	56
Pressure Ulcers	3
Baby born in poor condition/NNU admission	3
IUD	2
Infection Control	2
Deteriorating patient/failure to rescue	1
Surgical complication	1
Never Event: Retained guidewire	1
Patient absconsion and suicide	1
Human tissue Incident	1
Total	37

Safety Thermometer

Falls

In 2016/17 there was one fall that resulted in death and nine falls with severe harm that were investigated under the SI process.

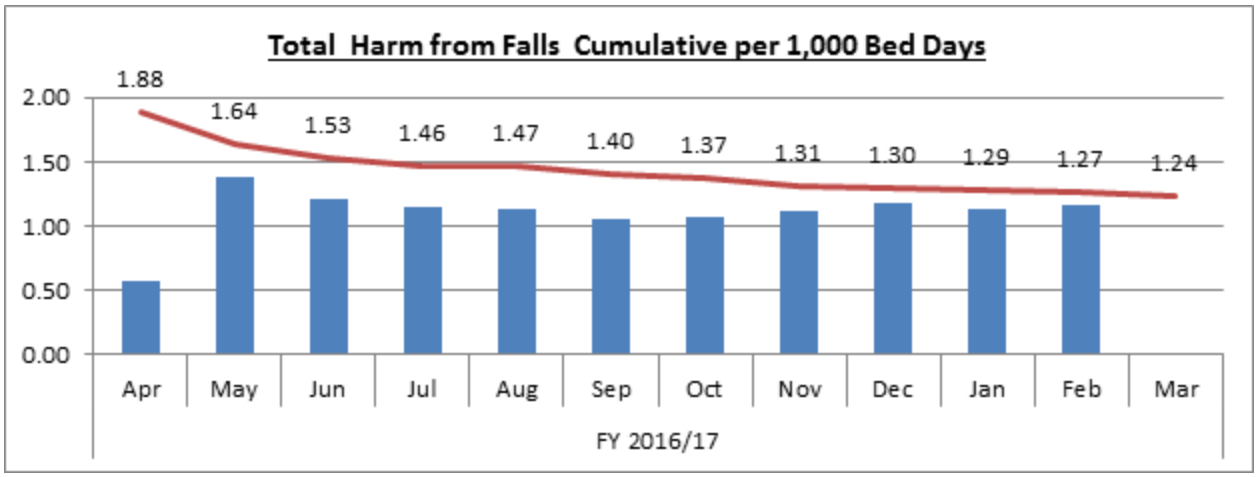
Falls counted numerically does not take into account fluctuations in hospital activity, therefore we are now measuring and reporting harm from falls in per 1,000 bed days. Improvement activity we have undertaken has led to a 58% reduction in total harm from falls per 1,000 bed days over the last two years (1.17 in 2016/17 from 2.77 in 2014/15).

A Falls Review Panel (including CCG representation) met in July 2015 and again in January 2017 to review all falls resulting in severe or moderate harm. The themes identified were:

- polypharmacy and high risk medications
- age if over 75
- impaired cognitive ability and
- previous falls in the last 12 months.

Recommendations were shared at a health economy-wide falls group which met for the first time in March 2017. We are now working collaboratively with our commissioners to ensure that community prevention strategies are aligned with hospital focused post fall strategies. It is recognised for example that elderly patients decondition for each day they are in hospital, so aligning falls improvement strategies with wider hospital work is vital, these include:

- Frail elderly work streams (Get me up, get me dressed, keep me moving)
- Discharge Improvement Group (Red2Green)
- Launch of a pilot programme of an activities coordinator
- Enhanced observation of patient pilot project across Bedford, Luton and Milton Keynes



It is important however that learning from the panel is shared more immediately and so lessons will be shared through:

- Quality Improvement Newsletter and a safety alert specifically relating to the findings of the thematic review.

- Quality board update on cohort / enhanced observation of patient pilot project.

Pressure Ulcers

Bedford Hospital has undertaken an improvement program since 2014 to reduce the prevalence of Hospital Acquired Pressure Ulcers (HAPU) and improve wound management.

In 2016/17, there were two avoidable category three pressure ulcers declared (compared to six in the previous financial year). This is a further improvement on last's year's performance.

In 2015 our Quality Improvement Strategy (QIS) identified HAPU as a key factor that required improvement and we have achieved substantial reductions in harm (greater than 50%) from HAPU since 2014/15 and predict a further reduction of 20% at year-end 2016/17.

We have achieved this through a number of activities outlined below:

- Pressure ulcer assessments risks are monitored monthly by matrons in the Nursing Quality Dashboard. This is reported monthly to the Quality Board and by exception to Clinical Risk and Quality Committee.
- A central database tracks all Hospital Acquired Pressure Ulcers (HAPU) and progress against trajectories.
- Link nurses are now in place on each ward and have quarterly meetings.
- Implementation of a trust-wide electronic referral to the Tissue Viability Nurse. This means that wards can now make referrals 24/7 rather than in office hours only.
- We have developed, with Hospedia (Extramed), and are rolling out an electronic SSKIN Bundle (Nurse Technology Fund) and repositioning chart. This will enable the Nurse at a glance to see what assessments are due and what risk the patient is at.
- To improve dynamic mattress availability, we reviewed our contract, changed suppliers and put a risk escalation process in place if a mattress could not be sourced for a patient within two hours.
- We have undertaken a full evaluation of equipment and medical devices used to relieve pressure and as a result over the last year have changed a number of devices which have improved pressure relieving properties including off-loading foam boots, silicon pads, oxygen masks and foam mattresses.

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

- Undertake a multi-disciplinary team thematic review of all HAPU and identify actions to improve reduction in HAPU and to share lessons learned
- Test new innovations to reduce harm from pressure, including trialling a new barrier cream for incontinence-associated dermatitis.
- Ensure clinical staff attendance at annual update by reviewing core staff groups who require annual clinical update in Stop the Pressure and report compliance monthly
- Review and develop STP-wide standardised education and training program for staff in each care setting.

Drug incidents

There were five serious incidents reported relating to medication in 2015/16. The five incidents were relating to different drugs/themes as follows:

- Omission of medication due to e-prescribing incident (Metavision)
- Anticoagulants prescribed when clinically contraindicated
- Ineffective anticoagulant dose prescribed
- Two anticoagulants concomitantly prescribed
- Anaesthetic drug inadvertently given to patient in error

As a result of these SIs, the trust is undertaking the following:

- E-prescribing (MetaVision) process on ITU updated to include further double checking of prescriptions
- Extensive work with e-prescribing company to build further fail-safes in to their processes
- Reminders to prescribers not to prescribe medication without reviewing patients notes
- Overarching Haemostasis & Thrombosis committee set up
- VTE risk assessment completion closely monitored and reported up via Quality governance structures
- Medical teams reminded to review entire drug chart at least once a day
- Trust anticoagulant bridging guidelines reissued to all prescribers
- Warning put in place on e-prescribing system (Medchart) to flag if tinzaparin is prescribed concomitantly with a NOAC
- Change to default anaesthetic agents used in obstetrics
- Procedure regarding drug preparation in theatre updated and disseminated
- Incidents discussed at Junior doctor teachings and audit meetings; continued publication of monthly Medication Safety Newsletter

Never events

In 2016/17 the trust reported one never event.

Synopsis:

A patient was admitted to critical care for haemofiltration. On admission a central venous catheter was inserted into the right internal jugular vein and a vascath for haemofiltration was also placed into the same vessel. Following insertion the doctor performing the procedure noted that the central line guidewire, that should have been removed post-insertion, was missing. A CXR was performed and reviewed by two doctors who were unable to see the guidewire. An abdominal x-ray was completed which identified the guidewire in the inferior vena cava/R iliac vein. The patient had the wire removed uneventfully by an interventional radiologist the following day.

Learning:

The learning from this case relates to the importance of carefully checking all equipment post-procedure. A reminder to staff was placed in the QI newsletter.

Patient experience

Complaints

The trust has a statutory obligation for the handling and consideration of complaints to ensure that they are dealt with efficiently, properly investigated and action is taken if necessary. Supporting the formal elements of complaints, the trust has a PALS which works with patients, relatives and carers to try and resolve their concerns informally and at local level.

A formal complaint involves a thorough investigation and the Chief Executive responds directly to the complainant. When investigating a complaint the trust is guided by national requirements, and has a local target of 45 working days to complete an investigation and respond to the complainant; for the majority of the year complaints have been responded to within 35-40 working days, this was driven by feedback from complainants who felt they had to wait too long for a response.

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

The trust endeavours to always provide a timely and satisfactory response to every complaint it receives. However, there are occasions when a complainant may not be satisfied with the initial response provided by the trust. If the trust's further efforts to resolve the issues; i.e. a further letter of response and offer a meeting for the complainant and the clinicians involved, are unsatisfactory to the complainant, the complainant is advised they can refer their complaint to the Parliamentary and Health Services Ombudsman (PHSO).

Overview

The trust has achieved a significant reduction in complaints over the last three years, this has been achieved by:

- 2014 - improved accessibility to PALs and complaints, streamlined administration process.
- 2015 – staff training on induction and clinical update, targeted training using patient videos, volunteers engaged to collect data on compliments, complainant survey, added actions to complaint responses.
- 2016 – improving quality of responses and proactive management of concerns, building a relationship with PHSO, reduce response time from 45 to 35 working days.

There were 252 complaints in 2015/16 compared to 120 in 2016/17 which is a reduction of 52%.

Parliamentary and health service ombudsman (PHSO)

The PHSO will investigate the case using information we provide and consider further investigation and recommendations. This year the trust has received nine final investigation reports.

One complaint which was partially upheld was originally accepted by the PHSO in 2014 and does not reflect the current robustness of our investigations or transparency of findings.

The other eight investigations have not been upheld as the trust has managed the complaints to the standard the PHSO would expect.

When a complaint is received by the trust it is triaged, to establish if the complaint is a formal complaint, a PALs concern, safeguarding concerns have been raised or the complaint may meet the criteria of a serious incident. Once the status of the complaint is established the categories are reported, this information is then used to establish themes of complaints and tailor training to fit the current trends.

Patient Advice and Liaison Service

The trust's PALS offers patients and their families or carers a point of contact for any concern, query or other feedback. It can facilitate communication between a patient and clinical areas. 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 detailed investigation.

In 2016/17, the trust recorded over 1000 formal PALS contacts.

Friends and Family Test (FFT)

Supporting the information from the in-patient 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 three core service areas:

- Accident and emergency
- Inpatients
- Maternity

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 2017/18 the trust will:

- Analyse the detail of responses especially where services may have low returns with negative scores which can affect the overall score
- Develop a programme of engaging with difficult to reach patients to improve response rates eg. in the care of the elderly.

- Review the qualitative feedback to form a development plan to improve the patient experience

Compliments

The trust is fortunate to receive a significant number of compliments including feedback, thank you cards, gifts and donations with this year the trust receiving over 4,500 compliments. These kind gestures from patients are provided at ward and service levels and include acknowledgements of individual members of staff and of services as a whole. Individuals and teams named in compliments are included in the weekly staff newsletter as part of our drive to celebrate achievements and successes. The donations category includes both monetary donations to the trust and donations of equipment. Small gifts, such as sweets and chocolates, are given frequently by patients to staff and are always gratefully received. Any larger gift items are declared to the trust board secretary. The trust aims to acknowledge each compliment and formally records them on the Datix system.

The general themes of compliments include:

- The treatment has been invaluable in helping the patient understand and improve her - should there be more here??

Learning from complaints and PALS

During 2016/17 the trust introduced a clearer process to identify learning to the complainant and staff. Responses from the chief executive inform the complainant where we have changed our practices as a result of their complaint:

- A monthly newsletter – QI - quality improvement newsletter - is circulated to all staff by email and hard copies are taken to each department by volunteers.
- Information and learning are shared on information triangles on tables in the staff canteen.
- Learning is shared at staff training at induction, clinical updates and targeted training at ward departmental level.
- The complaints team participate in training staff in root cause analysis, statement writing and giving evidence at coroner's court.

Next steps

- To 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 these actions will be monitored by the complaint satisfaction survey.
- Continue to engage with staff to ensure prompt local resolution to further reduce concerns.
- Improve patient experience by responding to when things go wrong and sharing good practice when patients have a good experience.

Dementia wards recognised for innovative improvements

In July 2016 Harpur and Elizabeth wards received an award of the 'Elder Friendly Quality Mark' in recognition of the support our staff gives to older people.

This brings the total number of wards in Britain which have achieved the Quality Mark to 32.

The Quality Mark is run by the Royal College of Psychiatrists and was developed in partnership with organisations including Royal College of Physicians, Royal College of Nursing and British Geriatrics Society. It has been established to encourage hospital wards to become involved in improving the quality of essential care of older people and to recognise good care provision, as identified by patient feedback.

The initiative was set up in response to reports over several years, including the Francis Inquiry Report (2013), which have highlighted the need for improvements, the importance of avoiding adverse outcomes in older people's care, and variations in the quality of care among wards.

The Quality Mark for Elder Friendly Hospital Wards is a voluntary national improvement programme established in Autumn 2012, with 111 wards participating to date. The hospital wards have focussed on the quality of essential care of patients aged 65 and above. The patient questionnaire measures satisfaction expressed by older patients with a series of quality statements about essential care on the ward and is not standards-based.

Patients over the age of 65 have been asked for their feedback about care, including their experiences of comfort, food and drink, support from staff, getting help when needed, and privacy and dignity. Patients have also been asked if they would be happy if a friend or family member was cared for on the ward.

To achieve the Quality Mark wards have:

- Taken part in a two stage assessment. Stage I involves assessing quality of care, which includes identifying areas of achievement and what could be improved. Stage II requires the ward to demonstrate continued focus on improving care for older people, and their progress.
- Collected information from patients, carers and visitors, ward staff and members of the multi-disciplinary team, the ward manager, a lead consultant working on the ward, hospital governors and the senior managers of the hospital/trust.

The Quality Mark is awarded to wards that have achieved high scores in stage II of the assessment. The award is for three years with an interim review. Wards joining the quality ward mark scheme commit to continuous focus on improving essential care based on feedback from our patients.

To find out more about the Quality Mark visit: www.wardqualitymark.org.uk

Ambulatory care launched

The trust launched the Ambulatory Emergency Care Unit (AECU) in September 2016 to assess, treat and discharge patients without the requirement for an overnight stay. We are a member of the NHS Ambulatory Emergency Care Network Cohort 9 (2016 - 2017) which includes 128 hospitals across the UK who have taken part and set up AECUs over the past 9 years.

AECU is staffed with a dedicated medical, nursing and administration team who review on average 20% of the daily emergency A&E likely admissions; and aim to discharge all patients following appropriate treatment. In addition, the service sees patients who return for routine procedures post DVT and Cellulitis diagnosis.

The next phase in our development will see:

- Our AECU move from the current temporary location to a dedicated area on the first floor in the main out-patient block. This move will enable there to be consultation rooms available in which surgical patients may receive minor treatments.
- Closer integration with our AAU medical team.
- Enhanced data collection.
- An increase in ward referrals for diagnostics, reviews and treatments.
- Strengthen weekend working.
- The establishment of direct access ambulance pathways for patients who meet the AECU inclusion criteria.
- Increase speciality in-reach to review patients on the day.
- Increased access to daily speciality HOT clinics.

Discharge planning

This has been a positive year for discharge planning. We have expanded our team and have seen several projects conclude resulting in positive changes being made that will further enhance the patients discharge.

Expanding the discharge team.

- We have recruited two band 6 nurses into the complex discharge team. They will undertake continuing Health Care assessments mainly in the community, enabling our patients to be discharged to a safe destination and have a period of convalescence before the assessment.
- A proposal to increase the team further has been approved. Further expansion will ensure that there is a discharge support worker on each ward managing the non-complex and the complex discharges. A qualified discharge nurse will manage two support workers.
- This will help to push our discharges to earlier in the day which will free up acute beds,thus reducing the wait time for patients in ED.

Moving the Hospital social work team and the Discharge team together.

- Plans are in place to locate the discharge team and the hospital team together in Weller Wing on site at the hospital. This will mean better face to face communication between the two teams. This can only benefit the patient discharge journey and I feel very positive that it will help to reduce length of stay.

Step-down community beds.

- We now have 18 step-down beds in the community. We use these beds for patients with complex discharge needs who are medically optimised and are waiting for assessment, new care, an increase in care, or for a permanent placement. This has worked really well with a patient's discharge still being managed by the hospital on a virtual ward. There are many benefits for the patient including avoiding the risks associated with deconditioning, acquiring infection, low mood and so on.

CHC Fast Tracks and End of Life patients

- A lot of joined up work has been done around our end of life patients. We have worked with our palliative nurse team and the Hospice at Home team to ensure that our processes are very tight and that we are not missing patients or seeing them too late. Our local audits revealed that some patients were not being identified as being end of life in time to transfer them out of the acute setting. It also identified that some junior doctors were reluctant to verbalise that a patient was at the end of their life making it very difficult to approach patients and their families to talk about where they wanted to die. Work is in progress and we are seeing an improvement. We are also now tracking all end of life patients on the complex discharge tracker so that they are discussed each day with the relevant professionals.

Greater collaborative working with our community colleagues

- We have set up a new pathway for the community alerts to be addressed by the hospital and have shared important contact numbers across organisations to enable the right person to be contacted first time thus reducing the amount of time it was taking to contact the hospital, especially for the community nurses. We have invited different community teams in to meet with the discharge team to talk through some of the frustrations they sometimes have with a discharge. This week we invited in key members of the rehab and enablement team. The meeting was very fruitful and benefited both teams which can only benefit our patients discharge.

NHS Staff Survey results

The trust performed well in the 2016 NHS Staff Survey, with a score of 3.82 (national average is 3.81) for overall staff engagement placing it in the top 20 percent of acute trusts nationally.

Table 3: Bedford Hospital NHS Trust's staff survey results 2016

Indicator	Bedford Hospital score 2016	Median national score 2016
KF21: percentage of staff believing the organisation provides equal opportunities for career progression/promotion	86%	85%
KF26: percentage of staff not experiencing harassment, bullying or abuse from staff in the last 12 months	22%	24%

Seven Day Services Clinical Standards

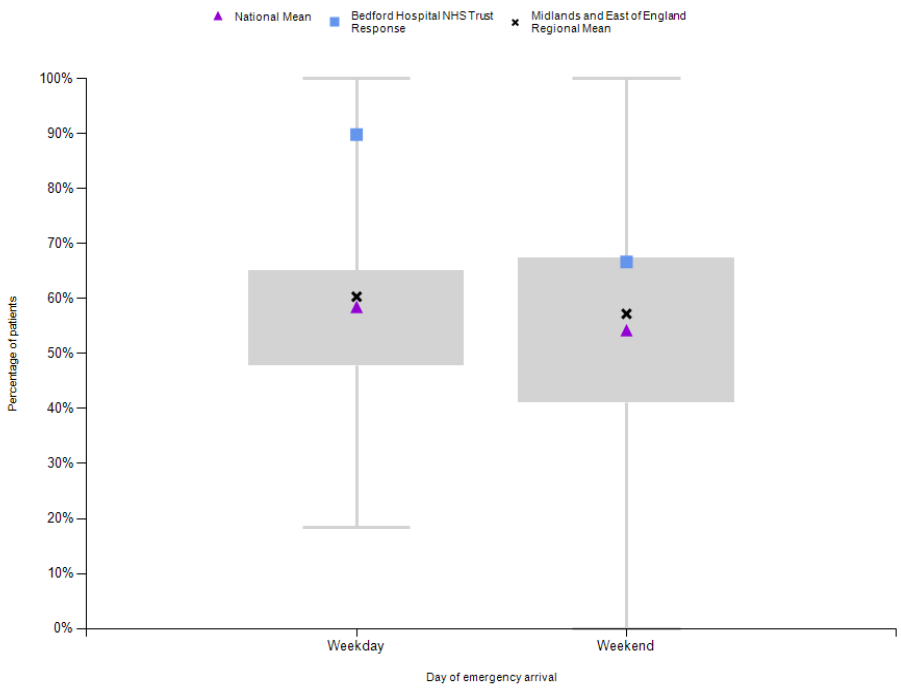
These were revised in February 2017 taking into account clinical feedback between June and December 2016. Relevant extracts are below.

Standard 2: time to first consultant review

All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital. A suitable consultant is a doctor who has completed all of their specialist training and been placed on the GMC's specialist register and is therefore trained and competent in dealing with emergency and acute presentations in the specialty concerned and is able to initiate a diagnostic and treatment plan.

The standard applies to emergency admissions via any route, not just the emergency department, for example admissions via radiology, consultant clinic and direct admission to AMU. If a patient is admitted from clinic, this consultation amounts to a first consultant review and meets this standard.

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



All patients should have a National Early Warning Score (NEWS) established at the time of admission. All patients admitted during the period of consultant presence on the acute ward (normally at least 08.00-20.00) should be seen and assessed by a doctor promptly, and seen and assessed by a consultant within six hours. Consultant involvement for patients considered 'high risk' (defined as where the risk of mortality is greater than 10%, or where a patient is unstable and not responding to treatment as expected), should be within one hour.

Patients with a clear diagnosis on a well-defined pathway (e.g. midwife-led maternity, simple superficial abscess management) may have their clinical care delegated from a consultant to another clinician under the following circumstances: there is a clear written local protocol for the pathway that has been agreed within the trust clinical governance system and that is supported by the commissioners; the protocol must describe actions to take in the event of clinical concern and that includes robust and rapid escalation to a consultant where appropriate e.g. a maternity patient who develops the need for an emergency Caesarean section or a patient with a superficial abscess who appears to be developing sepsis; and the patient's care is still recorded as being under a named consultant for the purpose of clinical governance (excluding patients specifically on midwife-led care pathways).

Standard 5: diagnostics

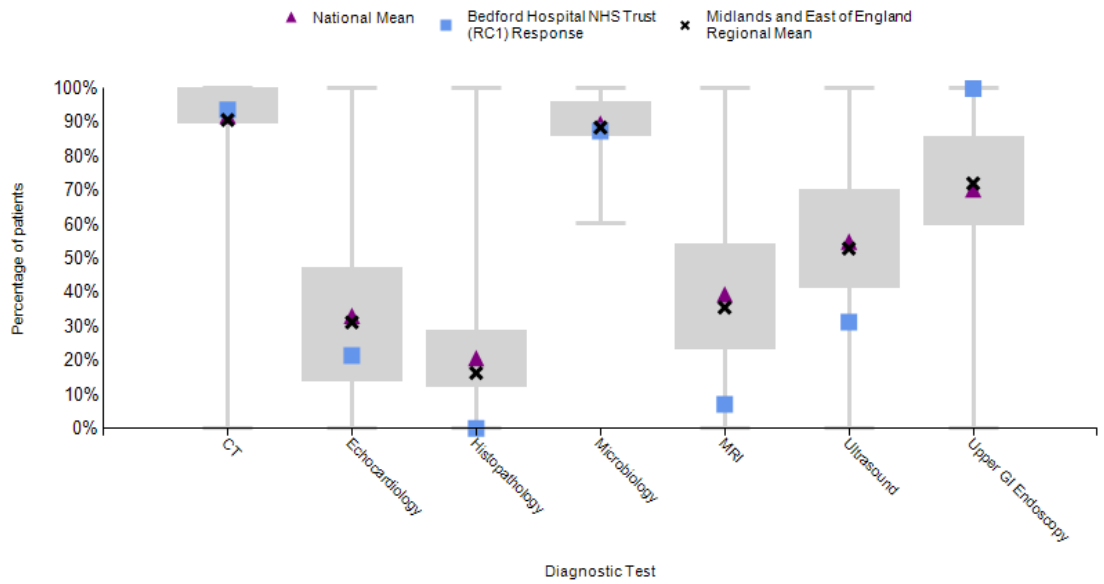
Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days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

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

Acute trusts should make a judgment through their clinical governance processes and in discussion with their commissioners regarding which diagnostic tests their patients require access to 7 days a week and whether these are delivered on site or via a formal networked arrangement. A networked approach may involve patient transfer, image transfer or diagnostician in-reach in differing circumstances.

The intention of the standard is to ensure that diagnostic tests are done within a specified period of time after the clinician in charge of the patient has requested them. The standard requires that diagnostic services are made available for patients to access; it does not set an expectation that clinicians should order tests inappropriately early in the care pathway. There is a very important role for watchful waiting to see how a patient's condition progresses.

Chart 3: Consultant responses reporting the diagnostic test is always or usually available when there is urgent clinical need at the weekend



Unless it is clinically indicated, patients should not remain in hospital solely for the purpose of receiving the diagnostic test they require.

Critical patients are considered those for whom the test will alter their management at the time; urgent patients are considered those for whom the test will alter their management but not necessarily that day. Standards are not sequential; if critical diagnostics are required they may precede the thorough clinical assessment by a suitable consultant in standard 2.

Investigation of diagnostic results should be seen and acted on promptly by the MDT, led by a competent decision maker.

Seven-day consultant presence in the radiology department is envisaged

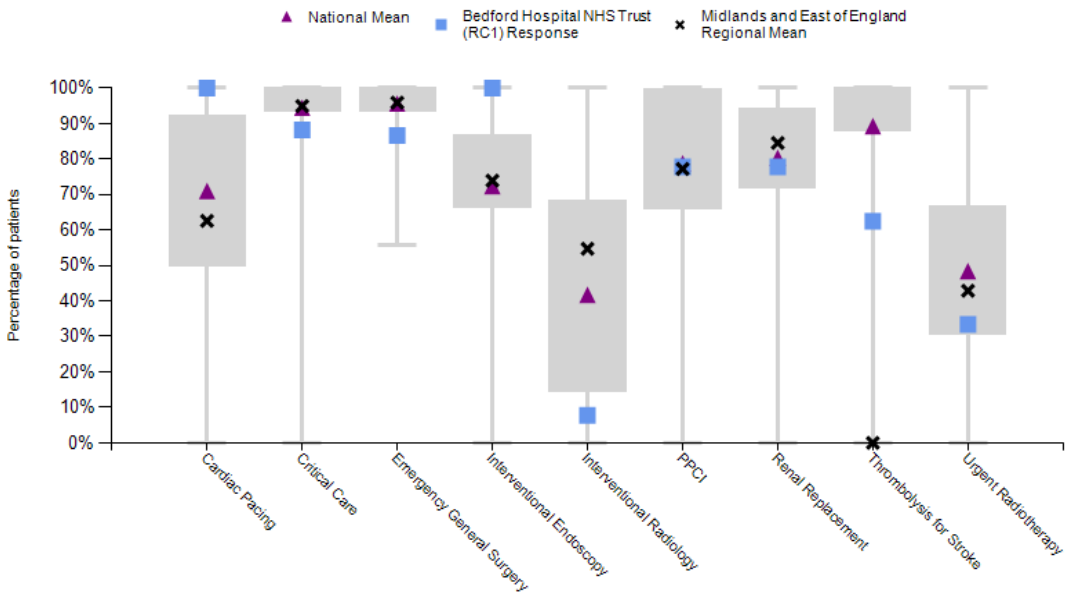
Standard 6: intervention / key services

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

- Critical care
- 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)

Standards are not sequential; if an intervention is required it may precede the thorough

Chart 3: Availability of interventions provided onsite or by formal provision (weekend)



clinical assessment by a suitable consultant in standard 2. The principle is that patients should receive urgent interventions within a timeframe that does not reduce the quality of their care (safety, experience and efficacy). Where there is evidence-based national clinical guidance regarding time to urgent treatment (e.g. thrombolysis for stroke, emergency laparotomy for peritonitis), trusts should implement systems to deliver to these standards and should monitor their performance.

Acute trusts should make a judgment through their clinical governance processes and in discussion with their commissioners regarding which interventions their patients require access to 7 days a week and whether these are delivered on site or via a formal networked arrangement.

Clear written protocols should describe any networked service arrangements, including a robust and transparent process for timely clinical assessment and patient transfer between sites. Such processes should be regularly audited to ensure that transferred patients receive timely high quality care. Trusts and their commissioners should have policies for managing a patient who is already in hospital and who develops another acute condition e.g. a general medical in-patient who then has a STEMI heart attack requiring primary PCI.

Standard 8: ongoing review

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

Definition of a consultant for this standard:

Consultants in this context are defined as doctors on the Specialist Register, CCT-holders and those recognised as being equivalent in the view of the relevant Royal College. These senior decision-makers have a crucial role, not just in identifying and dealing with clinical issues but also in communication with patients and relatives, in taking active and appropriate decisions about discharge from hospital, and in providing support and supervision and education to junior clinical colleagues. The term 'consultant' is maintained because it is believed that this is a term broadly understood by doctors and the public. This description of the consultant is included in this supporting information, to align the standard with professional opinion, and provide clarity on which senior doctors could provide ongoing review without compromising patient safety.

The purpose of the consultant review is to see any patient who is not on a pathway, to address patient deterioration, to provide urgent important communication with patients and carers where appropriate, to speed flow and remove blockages in the care pathway. There should be clear escalation protocols so that if a patient deteriorates in-between daily ward rounds there is appropriate timely clinical escalation. ('Seeing the sickest quickest').

Clinical judgement should be used to determine frequency of consultant review required, but as a guide patients with Intensive Care Society levels of need of 2 (3 for paediatrics) and above may require twice daily review, and patients with needs of below level 2 (3 for paediatrics) may only require once daily review. The group of patients who need twice daily

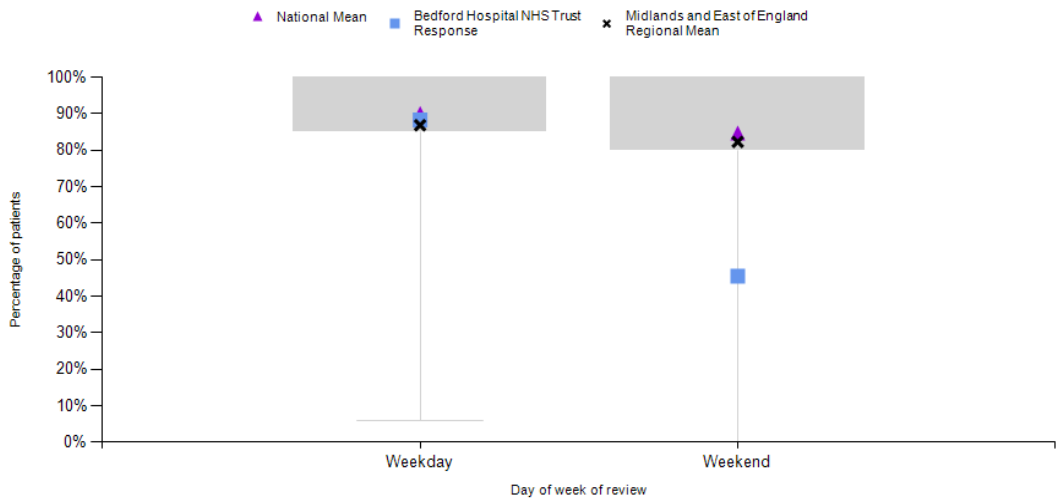
reviews should be based on the Intensive Care Society definitions of levels of illness and the Paediatric Intensive Care Society standards for the care of critically ill children rather than their geographical ward location in the hospital.

There should be consultant-led board rounds on every acute inpatient ward every day, and every patient should have a highly visible care plan (based on written protocols for individual conditions) that is updated daily at the Board round. At the Board round the consultant decides which, if any of the patients' reviews that day can be delegated to another competent clinician, such as a specialist nurse or senior medical trainee. The following are considerations that may be used to exclude individual patients from requirement for daily consultant review:

- The patient's physiological safety (low early warning score (EWS).
- The patient's level of need for further investigations and revision of diagnosis.
- The patient's level of need for therapeutic intervention.
- The level of need for communication with patient, carers, clinical colleagues.
- Their likelihood of imminent discharge.

For example patients who are medically fit for discharge and awaiting a social care placement (delayed transfers of care) may not need daily consultant review unless there are signs of clinical deterioration. The effective use of the skills and experience of a multidisciplinary team should be preserved, and this group will still need daily review with access to same day consultant advice.

Chart 2: Proportion of twice daily consultant reviews received



The decision that the patient does not need a daily consultant review should be documented, along with the plan for how the patient will be reviewed each day by the multi-disciplinary team (MDT) to ensure any signs of clinical deterioration are acted upon. Where a daily review is delegated the reviewer should feedback promptly to the consultant any concerns they have about a patient. Several examples exist of trusts that have segmented

their inpatient population to facilitate the appropriate level of daily review. Typically the groups are described as ‘medically active’, ‘medically optimised’ and ‘medically fit for discharge’.

The medically active group must be seen daily by a consultant and not delegated. This includes all patients causing nursing concern, all patients on end-of-life care pathways, all new admissions to a ward in the previous 24 hours and all patients in whom a potential same day discharge decision is required. The medically optimised group need daily consultant input via the board round, to ensure there is an MDT discussion around progress on therapy and social assessments, then for some in this group the consultant may choose to delegate that day’s face to face review to another member of the multi-disciplinary team.

What is required?

Standard 2

- Achievable within current resource
- Develop pathways for delegated care
- Midwifery-led care (assume pathway in place)
- Minor surgical conditions that do not require consultant review e.g. superficial abscess (Action: Planned Care); will require agreement of CCG
- Communicate to all consultants admitting acute patients (ongoing from MD); identify outliers and action by Divisional MD/CD if not comply

Standard 5

- Ultrasound
    - Business case required with the following options (Action: Integrated Medicine):
    - Daily Sat/Sun sonographer sessions (would achieve 24 hours standard)
    - On-call sonographer (to meet 12 hour standard for urgent)
    - Resident sonographer (to meet 1 hour standard for critical): likely to be unachievable/unaffordable
- CT
    - 24 hour standard for non-urgent requires change in mindset but should be achievable within current resource
    - 12 hour standard for urgent achievable within current resource
    - 1 hour standard for critical achievable but time-limited nature requires increased emphasis
- MRI
    - Business case required with the following options (Action: Integrated Medicine):
    - Daily Sat/Sun MRI sessions; requires onsite MR radiographer and radiologist reporting (STP networked solution? outsourcing?) (would achieve 24 hours standard)
    - Networked access to daily Sat/Sun MRI sessions (STP?) (would achieve 24 hours standard)
    - On-call MR radiographer or access to networked solution (STP/ tertiary) (to meet 12 hour standard for urgent)
    - Resident MR radiographer and access to reporting (to meet 1 hour standard for critical): likely to be unachievable/unaffordable

- Microbiology
    - Networked on-call service in place which will meet standards
- •Echo
    - Business case required with the following options (Action: Integrated Medicine):
    - Daily Sat/Sun echo sessions (would achieve 24 hours standard)
    - On-call echo technician (to meet 12 hour standard for urgent)
    - Resident echo technician (to meet 1 hour standard for critical): likely to be unachievable/unaffordable
- Endoscopy
    - Emergency endoscopy service in place; achievement of 1 hour critical target challenging

Standard 6

- Critical care
    - No additional resource required
- Interventional radiology
    - No resource available within the STP to deliver 24 hour, 12 hour or 1 hour standard. Requires a solution to be developed either with neighbouring STP or formal SLA to tertiary service (1 hour critical standard would be impossible to achieve with the latter). (Action: STP radiology lead; Integrated Medicine)
- Interventional endoscopy
    - Emergency endoscopy service in place; achievement of 1 hour critical target challenging.
- Emergency general surgery
    - Emergency general surgery service in place; achievement of 1 hour critical target challenging depending on availability of emergency theatre.
- Emergency renal replacement therapy
    - No additional resource required as available on CCC
- Urgent radiotherapy
    - Networked service with Addenbrooke's. 1 hour critical target may not be achievable if patient requires transfer
- Stroke thrombolysis
    - HASU L&D
- Percutaneous Coronary Intervention
    - Papworth service. 1 hour critical target may not be achievable if patient requires transfer
- Cardiac pacing (either temporary via internal wire or permanent)
    - Current status and gap analysis to achieve 24 hour, 12 hour and 1 hour standards (latter may be difficult to achieve unless resident on site) (Action: Integrated Medicine)

Standard 8

- Twice daily review

The definitions have been amended as to who should require twice daily review and this is now based on the ICS level of need. Level 2 equates to an HDU patient (or those requiring

CCC outreach). It should also relate to acutely admitted patients without a clear pathway. To meet the standard therefore we should review:

- all admissions to AAU unless deemed stable with a clear management plan in which case once daily review
- all inpatients who deteriorate and require CCC outreach

This should not require additional resource but managed within existing workload.

- Once daily review

Planned Care

Expectation is that all patients will be reviewed daily by a consultant in the relevant specialty. This needs reinforcement by the Divisional CD/ Divisional Director (Action: Planned Care).

Integrated Medicine

Consider segmenting inpatients to medically active, medically optimised and MFD using definitions above; for business planning purposes snapshot audit needed to determine the relative proportion. (Action: Integrated Medicine)

- medically active: require a consultant review daily
- medically optimised: require a consultant-directed board round and either consultant or delegated (middle grade) review
- medically fit for discharge require multidisciplinary review; this could be a matron.

Business case required on the basis of the snapshot audit to determine what additional staff are required to deliver this (Action: Integrated Medicine).

Quality improvement strategy

Following the CQC inspection in December 2015, the trust developed an action plan to deliver the inspection outcomes. The action plan, which supported the quality improvement strategy, concentrated on delivering the actions to support the CQC requirement notices.

The trust submitted a closed action plan on the requirement notices in January 2017 and continues to delivery on the 'should do' actions.

Background

There were four requirement notices which the trust closed formally with the CQC, NHSI and CCG in January 2017.

Currently, ten (out of 33) should-do actions remain open. Delivery of these actions are:

- The responsibility of the divisions
- Monitored through CQPs at quality board
- Challenged and monitored at the CQC steering group

To match the delivering of the action plan and to ensure the trust is prepared for the next inspection, the original quality improvement group developed into the CQC steering group.

CQC Steering Group

The steering group, which receives upward reports from the core service and support services leads, will move from monthly to fortnightly meetings to ensure momentum and acknowledge the positive achievements being delivered.

Monitoring action plan

The outstanding 'red risk' to delivery was regraded to amber with mitigation's in place. The risk related to a reduction in delays in transfer form critical care to ward. Due to capacity issues there are sometimes slight delays in good practice in transferring patients but:

- There has been no adverse effect on patients in being delayed
- There is no delay in accepting patients into critical care – which is a higher priority for the trust
- Critical care have safer care bundles in place to monitor and manage CC patients once they are able to leave but remain on the unit
- This action remains on the trust risk register
- The trust is working with CCG on wider capacity issues and adverse effects on patients

Regular confirm and challenge meetings (CCM) have been held with clinical leaders and the director of nursing. Each service that received the rating, requires improvement, was a priority followed by other services. This was to establish preparedness and triangulation of information, complaints, audit, serious incidents, guidelines and risk registers.

Annex one: services provided by Bedford Hospital NHS Trust in 2015/16

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

Midwifery	Pharmacy
Neonatal	Physiotherapy
Nephrology**	Speech and language therapy****
Neurology	Theatres
Obstetrics	Acute admissions unit

* indicates a laboratory service provided by Viapath

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

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

**** indicates a service provided by South Essex Partnership Trust (SEPT)

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

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

Bedfordshire Clinical Commissioning Group

Bedford Borough Council Adult Services and Health Overview and Scrutiny Committee

Central Bedfordshire Council Adult Services and Health Overview and Scrutiny Committee

Healthwatch Bedford Borough

Healthwatch Central Bedfordshire

Annex three: statement of directors' responsibilities

To be inserted

Annex four: external audit limited assurance report

To be inserted

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
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
FFT	Friends And Family Test
GMC	General Medical Council
GP	General Practitioner
GRS	Global Rating Scale
GUM	Genitourinary Medicine
HHS	Hyperosmolar Hyperglycaemic State
HPA	Health Protection Agency
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
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
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
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
PCNL	Percutaneous Nephrolithotomy
PHSO	Parliamentary And Health Service Ombudsman
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
SHMI	Summary Hospital-Level Mortality Indicator
SHO	Senior House Officer
SSNAP	Sentinel Stroke National Audit Programme
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