Appendix A

Bedford Hospital NHS Trust
Quality Account 2015/16

Consultation draft

Contents

Part 1: Statement on Quality from the Chief Executive

Last year I promised that we would continue to deliver improvements across clinical quality and patient experience.

- Achieving that commitment has been demonstrated by our clinical outcomes:
- we have lowered our mortality rate – the number of deaths measured in relation to our population – to below the national average;
- the number of patients being harmed by falling in hospital has reduced;
- and the number of pressure ulcers acquired while a patient is in hospital has reduced; and
- while in hospital, the number of patients who suffer a thrombosis has also reduced.

We work closely with our neighbouring hospitals to ensure that we, as a group. provide the best care - clinically effective and of the highest quality. For example, our vascular centre, cancers services with Addenbrookes and ophthalmology with Moorfields. We have been working closely with our commissioners and the local authority to improve and develop processes and support so that patients are able to leave hospital when they are medically fit and return to their homes or other suitable accommodation and carry on being treated and supported in the community.

We work with our commissioners to ensure that while we are delivering on our contractual obligations (including incentives and penalties to improve quality, as well as addressing our financial responsibilities. Overall, we are maintaining and further developing the quality of care our patients receive.

We have continued to work closely with our patients, through our partnership with Healthwatch and our patient's council. Having the patient voice in helping us design and deliver care is important and fundamental to our developments and achievements. It will be central to us developing our actions plans for the coming year following our CQC inspection.

REGULATORY OVERSIGHT

CQC

The year saw us welcome the health regulator – Care Quality Commission (CQC) – into the trust. Since the last visit in 2014 we have made enormous improvements across all areas of the hospital – specifically within the quality of care we provide to our patients.

The inspection took place in December and our 2,300 staff worked tirelessly to prepare for the visit while continuing to delivery great care and treatment to our patients. The inspection was carried out by over 50 inspectors who reviewed eight 'core services' by:

- speaking with patients, staff, partners;
- reviewed notes, systems, policies and procedures; and
- visited all clinical areas of the hospital watching how we treated and cared for our patients.

The outcome of the inspection rated us overall as 'requires improvement'. We understand the areas that the CQC had concerns about and we were able to rectify most of these at the time of the inspection. We will be developing a quality improvement plan for the coming year to address the immediate issues and the longer term cultural and infrastructure issues, for example, the speed with which we identify and share learning when incidents occur.

We welcomed a number of scrutiny visits from either our regulator or other professional body.

- Our PLACE survey benchmarked us against the national picture and while we stood out for our cleaning and catering we do need to do more work on the privacy issue of our patients, particularly in relation to boredom as an inpatient; not having access to a television or radio
- A visit by the GMC (doctor regulator) to review how we supported junior doctors and doctors in training, found that doctors feel they are listened to, can help shape issues, have a positive culture of learning and have numerous methods for raising issues
- We ensured minimal disruption to patients care during the number of junior doctors strikes over the course of the year
- A national benchmark for our openness and learning placed us 94 out of 230 health organisations
- IT rating - tbc

NEXT YEAR

Our reflections of the year and the feedback from the CQC have helped us to shape our priorities for 2016/17. We have developed the quality improvement plan in line with our quality strategy priorities and our trust objectives so we have one direction with clear aims and outcomes.

- A key task for next year is stabilising our financial position will help us to secure the foundations of the long term sustainability of the hospital

The next twelve months will be a challenging and exciting time for the trust. Our staff have done a fantastic job in improving quality and they are keen to address the CQC actions. I look forward to continuing our improvement journey with our stakeholders and partners

Stephen Conroy
Chief Executive Officer

Part 2: Quality Improvement priorities 2015/16:

In the 2014/15 Quality Account the Trust identified three quality improvement priorities for 2015/16:

1. Patient safety improvement priority: Continue to reduce incidence of avoidable harm (e.g. pressure ulcers, falls, venous thromboembolic disease and infection)
2. Patient experience improvement priority: Improve the information provided to patients and relatives at the point of discharge
3. Clinical effectiveness improvement priority: Introduce a 'Hospital at Home' service as an alternative for patients who do not need to stay in hospital for their care and treatment (to help avoid admissions and reduce the length of stay)

The Trust's progress in achieving these improvement priorities is presented in pages 8 to 15.

Patient safety priority 2015/16: Continue to reduce incidence of avoidable harm

Aim

In last year's Quality Account prioritised the continued reduction of the incidence of avoidable harm experienced by our patients whilst receiving care and treatment at the trust.

Targets for 2015/16

1. Reduce the number of MRSA blood infections to zero
2. Reduce the number of hospital-apportioned *Clostridium difficile* infections to below 10 cases per year
3. Reduce the maximum ceiling for hospital acquired avoidable grade 2 pressure ulcers by 50 percent (35 in 2014/15 to seventeen in 2015/16) and not exceed either ceiling
4. Achieve 95 percent venous thromboembolism (VTE) assessment rate

Progress against targets

A summary of the trust's performance against the targets is provided in Table 1.

Table 1: Performance against 2015/16 patient safety improvement priorities

Target	Target achieved	Performance
Zero MRSA blood infections		One MRSA blood infection reported in April 2015
Less than ten hospital-apportioned *Clostridium difficile* infections		23 cases hospital-apportioned *Clostridium difficile* infections
Less than 17 hospital acquired avoidable grade 2 pressure ulcers		10 hospital acquired avoidable grade 2 pressure ulcers
95 percent venous thromboembolism (VTE) assessment rate		95.16%

The trust met two targets in full, one partially as the MRSA infection occurred very early in 2015 and one target was unmet against the four patient safety targets 2015/16. There were 23 cases of *Clostridium difficile* Infection which was above our trajectory by 13 with 6 of these cases yet to be validated as hospital acquired. However investigation of these cases indicated that whilst there was no transmission from patient to patient there were lessons to be learnt. We have therefore joined a national collaborative with NHS Improvement in this area for 2016/17. Other areas of patient safety activity have delivered improvements throughout the year and are detailed in the following paragraphs.

Quality Improvement Strategy

The Quality Improvement Strategy and Sign up to Safety campaign were both approved by the Trust Board in July 2015.

The Quality Improvement Strategy was launched across the trust in the autumn of 2015 through a series of informal events where staff were invited to have conversations about quality with the trust leads for:

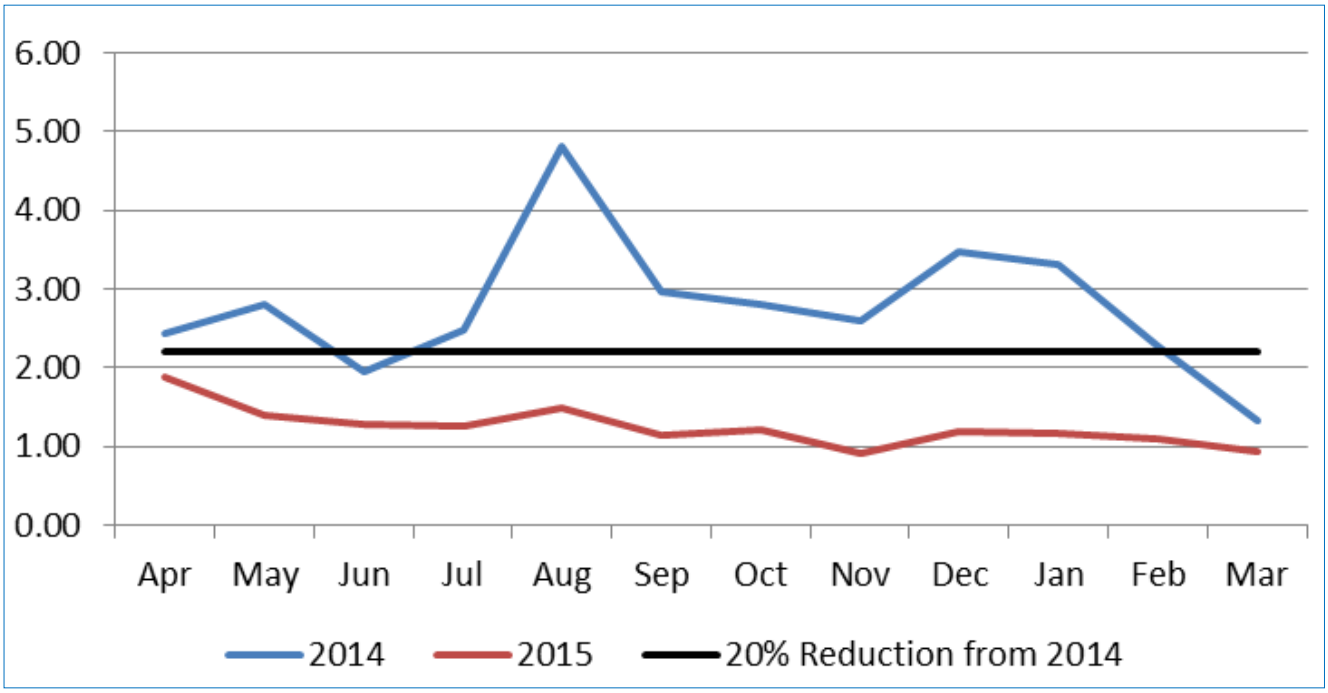
- Safe care minimize harm
- Reliable care
- Patient experience
- Learning and Quality culture
- Effective Governance and Leadership

Part of our improvment stategy is to develop the capability of our staff to make improvements. A group of seventeen staff undertook a quality improvement development programme leading to 12 workplace projects some of which led to trustwide improvements in safety, patient expereince and effectivness.

Falls resulting in harm

Patient Safety First state that the recommended outcome measure for determining whether change has an effect, is to calculate the rate of harm per thousand occupied bed days. Due to improvement work the trust's rate of falls resulting in harm per 1000 bed days has continually reduced over 2015/16 and remained under the ceiling of a 20 percent reduction against the 2014/15 average. As Figure 1 shows, the rate of harm per 1000 bed days has averaged 1.25 in 2015/16 compared to 2.77 in 2014/15.

Figure 1: Rate of falls resulting in harm per 1000 bed days



Improvements to the serious incident process

Following the CQC inspection in December 2015, the trust reviewed an updated its Serious incident (SI) policy to strengthen the following aspects:

- Changes to the SI screening form to capture:
  - Immediate actions taken post incident to safeguard patient/other patients, service users and staff
  - Executive sponsor (in addition to lead investigator)
  - Any further actions required
  - Any immediate learning identified and how this will be communicated to staff *(see learning section below)*
- Update the 3-day report to capture immediate learning
- Where appropriate this learning is now shared across the trust via its internal Patient Safety Alert newsletter

- All 3-day report are now approved by Divisional Lead Nurse and/or Divisional Medical Director prior to submission to the Clinical Governance Team
- Monitoring of 3-day reports by Clinical Governance to ensure all reports are of a consistent standard
- Final investigation report templates have bene updated to include identification of local and trust-wide learning, and statements from investigators confirming there is no conflict of interest
- The trust's monthly Quality Improvement Newsletter includes wider learning from SIs, complaints and claims

Further details on the trust's plans to continue to improve the investigation of and learning from Serious Incidents is provided (page 18).

Nursing assessment tools

The trust's nurse specialists reviewed all nursing assessment tools as part of the Nurse Technology Fund improvement project. The new comprehensive assessment tool now incorporates the latest in national and local guidance. The electronic assessment tool is currently being piloted on the trusts care of the elderly wards, and plans are in place to roll out across all wards during 2016/17.

Implementation of electronic risk assessments and care plans for key patient risks (such as infections, falls, pressure prevention and nutrition) will enable the trust to monitor effectiveness in real time.

Customer care training

The trust has commissioned bespoke customer care training for front line staff in A&E and the Acute Assessment Unit. This is in response to feedback from patients, comments on Friends and Family Test surveys and complaints to help staff to better respond to patients during times of heightened stress and uncertainty. This will take place in May 2016.

Additional achievements include:

- ✓ Reviewed and development of training for clinicians to carry out quality investigations to include human factors
- ✓ Development of business partner model of incident investigation and shared learning
- ✓ Launch of the trust-wide monthly incident learning newsletter – *Quality Improvement*

- ✓ Developed the capability of our staff to make improvements by providing access to a quality improvement development program in conjunction with University of Bedford.
- ✓ Undertook thematic reviews with a range of healthcare partners including our commissioners to review of serious incidents relating to falls. This lead to an improvement action plan and a subsequent reduction in harm from falls.

Patient experience priority 2015/16: Improve the information provided to patients and relatives at the point of discharge

Aim

The trust aimed to improve the information it provides to patients and their relatives when they leave hospital.

Targets for 2015/16

The targets related to the implementation of two new patient information packs:

- 'Helping You Plan to Leave Hospital' information booklet, mandatory for all inpatients
- 'Place of Discharge Toolkit' for people with complex discharge needs (e.g. patients requiring discharge to a new place of residence such as nursing/residential home)

Progress made in 2015/16

Target	2015/16 Performance	Summary
Implement the 'Helping You Plan to Leave Hospital' information booklet for all inpatients.		The trust has partially achieved this target. All patients on elderly frail wards receive the booklet with a covering letter explaining how the discharge team can help patients and their families. The trust discharge planning team is responsible for ensuring patients on the elderly frail wards receive the booklet and appropriate support. This is monitored by the trust's lead matron for discharge. The trust plans to roll out the use of the booklet to all wards in 2016/17.

Implement a discharge information pack (the Place of Discharge Toolkit) tailored to meet the needs of patients with more complex discharge requirements will be implemented across the Trust.		The trust provide patients and their carers and relatives with an information pack that guides them through the complex process of finding new nursing and residential homes. This pack is due to be updated in 2106/17 to be compliant with the new requirements of the Care Act 2015 and new social care charges. We also include a leaflet for the Bedford Hospital carers lounge which provides free and independent support and advice.

- ✓ The trust has continued to provide the support of discharge planners to carers or relatives during the process of finding, visiting and choosing a residential or nursing home for a patient. This service continues to be offered to carers and relatives of elderly patients and has been shown to be beneficial to both the patient and relatives.
- ✓ The trust implemented an electronic discharge checklist which is a mandatory for all adult inpatient discharges. The checklist is comprehensive and helps to ensure that communication to carers and family has happened before discharge.
- ✓ To further extend access to patient information that meets their language Improvements made in 2015/16.
- ✓ In addition 80% of Bedford Hospital wards and department s have a dignity champion and we have promoted the use of dignity clips and hearing loops on wards as a method to improve communication and maintain privacy

Further improvements include:

- ✓ A charity which offers support to Bedford Hospital saw success at the Patient Experience Network National Awards. The Carers in Bedfordshire charity run the Carers' Lounge at Bedford Hospital and it won the category of Support for Caregivers, Friends and Family. The Carers' Lounge is run in partnership with the hospital and is supported by Bedford Borough Council and since it opened in 2012, more than 5,600 unpaid family carers looking after a loved one have been contacted through the service.

  The lounge gives carers of any age visiting the hospital a safe, confidential, non-judgmental space where they can find support, information and advice.

Staffed by lounge co-ordinator, Christina Offord, and a team of carers' support workers, benefits advisors and volunteers, carers can access support Monday to Friday between 11am and 6pm.

The Carers' Lounge team (below)work with staff across the hospital to identify and support carers as well as with organisations including Age UK, the Alzheimers Society and the Stroke Association to ensure carers have access to all the information and support they need.

Clinical effectiveness priority 2015/16: Introduce a 'Hospital at Home' service

Aim

In 2015/16 the trust aimed to introduce the Hospital at Home service to help reduce the length of stay of patients who do not need to be in hospital to receive their care and treatment.

Target for 2015/16

The trust set a target of increasing the provision of the Hospital at Home service from eight to 15 'virtual' beds. In order to achieve this, the trust needed to recruit two whole time equivalent (WTE) Band 6 nurses to the service.

Progress made in 2015/16

Target	2015/16 Performance	Summary
Recruit two whole time equivalent (WTE) band 6 nurses to the Hospital at Home Service		The trust were unable to achieve the additional funding required for the posts in 2015/16, however we were able to flex the service based on patient demand and we were often able to increase the virtual ward to 10 or more beds. The trust has introduced a 'patient tracker' system for patients under the complex discharge team. This allows the team to support patients as they move through the hospital until discharge. The system also provides greater transparency for our partners as this provides a daily picture of patients who are fit for discharge yet remain in hospital.

- ✓ Within the existing establishment the Hospital at Home team nursed over 200 patients between March 2015 and March 2016, saving over 2000 bed days.
- ✓ The service has provided support and help to patients and their families at extremely challenging times. For example, a female patient with cancer who required intravenous medication. Admission to hospital would have meant being separated from her young children. Instead the patient was nursed at home, with the consultant keeping track of her progress via the Hospital at Home nurse. This meant the patient was able to spend time at home, instead of in hospital, with her young family in the last months of her life.
- ✓ A senior member of the complex discharge planning team has been designated to lead continuing healthcare fast track discharges. These are patients who are near the end of their life and cannot return home without care and specialist equipment or need to be placed in a nursing home. Previously discharge planners responsible for individual wards managed fast track discharges as they occurred. Since the designation of the CHC fast track responsibilities to one senior member of the team, the discharge process for patients nearing the end of their lives has become quicker and support from additional sources has increased (e.g. voluntary sector support).

Quality Improvement Priorities for 2016/17

In December 2015 the Care Quality Commission undertook a planned, comprehensive inspection of the trust. The outcome of the inspection and the trust's plans to address areas requiring improvement are provided on pages 18 to 21.

As such, the trust's quality improvement priorities for 2016/17 are based on three themes for improvement identified by CQC. These are:

1. Patient safety: Improve learning following never events, incidents and complaints to prevent avoidable harm.
2. Patient experience: Build on good practice in maintaining privacy and respecting outpatient areas and to further improve the range of patient information in languages other than English.
3. Clinical effectiveness: Benchmark clinical outcomes of care to drive improvement for patients

Patient safety improvement priority 2016/17: Develop and implement a framework for learning from never events, incidents and complaints to reduce avoidable harm

Following its inspection of the trust in December 2015, CQC issued a requirement notice in relation to good governance. Within the overarching plan the trust has developed to address all areas for improvement identified by CQC, the trust has established four strategic work streams to oversee trust-wide changes:

- Governance
- Workforce
- Patient experience
- Estates

Target for 2016/17

Develop and implement the trust's learning framework and demonstrate improved learning from incidents, never events and complaints across all staff groups

Planned improvements for 2016/17

The Trust plans to implement the following improvement activities in 2016/17

- Develop further the business partner model to support divisions in quality of investigations and related incidents
- To develop cascade and learning mechanisms (vertically and horizontally)
- To support clinical divisions in quality and learning committees and identifying key areas for learning
- To link with other trusts who demonstrate a positive learning culture to identify process and projects that will support improvements in this trust
- To review and develop a more accountable learning culture
- To develop the capability our staff so that they understand how to make improvements

How we will measure, monitor and report on our progress

This improvement priority links directly with a CQC requirement notice (see page 37). Progress against the detailed action plan will monitored by the Governance work stream and reported to the trust's Quality Board on a monthly basis.

Patient experience improvement priority 2016/17: Build on good practice in maintaining privacy and respect in outpatient areas and further improve the range of patient information in languages other than English.

CQC recommended that the trust should provide patient information leaflets in languages other than English in order to meet the language and communication needs of the local population.

Targets for 2016/17

To ensure patients have their outpatients and emergency consultation provided with privacy and respect by ensuring that measures are taken to ensure private conversations are not overheard.

To further extend access to patient information that meets their language needs.

Planned improvements for 2016/17

The Trust plans to implement the following improvement activities in 2016/17:

- Engage partners to undertake further work on maintain privacy and dignity across outpatient areas
- Identify the core range of patient information and update accordingly
- Implement a systematic process for translation of core patient information to the languages most commonly used by the local population
- Ensure patients are aware of the service available to translate information by developing a patient translation services information booklet (in a range of languages).

How we will measure, monitor and report on our progress

The trust will develop a performance metric (e.g. percentage of information leaflets available in translation) and report quarterly via established quality monitoring framework to the Quality Board.

Clinical effectiveness improvement priority 2016/17: Improve the implementation of plans to improve outcomes against national audits

Aim

To improve patient outcomes against national audits

Target for 2016/17

For all national audits where patient outcomes are below average, the trust will develop and implement action plans to improve patient outcomes

Planned improvements for 2016/17

In order to achieve the target of having action plans in place for all national audits within which the trust performs below average, the following improvements will be make:

- The trust will map the publication date for all annual reports for continuous audit programmes
- The clinical audit policy will be reviewed and strengthened to incorporate the requirement that in the event of the trust performing below average in any national audit, the clinical lead must develop an action plan within three months of receipt of the annual report with clear objectives and timescales for delivery
- A business case for additional administrative support for national audits within the clinical audit department will be developed

How we will measure, monitor and report on our progress

- Each division will receive a monthly report (contained with the Clinical Quality Portfolio) detailing annual reports received, due date for action plans, clinical lead and progress in implementing actions
- Divisions will report upwards to the trust's Quality Board

Statements of Assurance from the Board

Review of services provided by Bedford Hospital NHS Trust

During 2015/16, Bedford Hospital NHS Trust provided 41 relevant health services and sub-contracted 12 relevant health services. A list of all services provided by the Trust is located in Annex 1.

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 2015/16 represents 100 percent of the total income generated from the provision of relevant health services by Bedford Hospital NHS Trust for 2015/16.

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 that of other hospitals.

During 2015/16, 43 national clinical audits covered relevant health services that Bedford Hospital NHS Trust provides.

During 2015/16 Bedford Hospital NHS Trust participated in 98% (43/44) of national clinical audits.

The national clinical audits that Bedford Hospital NHS Trust was eligible to participate in during 2015/16 are as follows:

- Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)
- Adult Critical Care (ICNARC)
- Bowel Cancer (NBOCAP)
- Cardiac Arrhythmia
- Case mix Programme (ICNARC)
- Community Acquired Pneumonia Audit (CAP) (BTS)
- Coronary Angioplasty
- Diabetes (Paediatric) (NPDA)
- Paediatric diabetes PREM survey 2015 (NPDA)
- Elective Surgery (National PROMs programme)
- Emergency Use of Oxygen Audit (BTS)
- End of Life Care Audit: Dying in Hospital
- Endocrine and Thyroid National Audit
- Inflammatory Bowel Disease (IBD)
- Head and Neck Oncology (DAHNO)
- Major Trauma Audit(Trauma Audit and Research Network, TARN)
- Maternal, Newborn and Infant Clinical Outcome Review Programme (MBBRACE)

- National Cardiac Arrest Audit (NCAA)
- National Cardiac Rehabilitation Audit
- National Chronic Obstructive Pulmonary Disease (COPD) Audit programme – Pulmonary Rehab
- National Comparative Audit of Blood Transfusion Programme
- Patient blood management in scheduled surgery
- Use of blood in Haematology

  National Diabetes audit and:
- NADIA National Diabetes inpatient audit
- NPID Pregnancy in Diabetes audit
- NDFA: National Diabetes Foot Care Audit
- National Emergency Laparotomy Audit (NELA)
- National Heart Failure Audit
- National Hip fracture database (NHFD), includes Falls and Fragility Fractures audit (FFAP)
- National Joint Registry (NJR)
- National Lung Cancer Audit (NLCA)
- National Prostate Cancer Audit
- National Vascular Registry
- Neonatal Intensive and Special Care (NNAP
- Oesophago-gastric Cancer (NAOGC)
- Paediatric Asthma
- Percutaneous Nephrolithotomy (PCNL) Audit
- Procedural Sedation in Adults (care in emergency departments)
- Sentinel Stroke National Audit Programme (SSNAP)
- Stress Urinary Incontinence Audit
- Rheumatoid and early inflammatory arthritis audit
- UK Parkinson's Audit
- Vital signs in children (care in emergency departments)
- VTE risk in lower limb immobilisation (care in emergency departments)

The national clinical audits that Bedford Hospital NHS Trust participated in, and for which data collection was completed during 2015/16, are listed in Table 2.

Table 2: Bedford Hospital NHS Trust participation in national clinical audits

National Audit	Percentage participation/Continuous
Acute Coronary Syndrome or Acute Myocardial Infarction	Continuous
Adult Critical Care (ICNARC)	Continuous
Bowel Cancer (NBOCAP)	Continuous
Cardiac Arrhythmia	Continuous
Case mix Programme (ICNARC)	Continuous
Coronary angioplasty (NICOR Adult Cardiac Interventions Audit)	Continuous
Diabetes (Paediatric) (NPDA)	Continuous
Elective surgery (National PROMS programme)	Continuous
Emergency Use of Oxygen Audit (BTS)	100% (37/37)
End of Life Care Audit: Dying in Hospital	100% (51/51)
Endoscopy Audits (38 topics)	Continuous
Endocrine and Thyroid National Audit	Continuous
Inflammatory Bowel Disease audit	Continuous
Head and Neck Oncology (DAHNO)	Continuous
Major Trauma Audit (Trauma Audit & Research Network)	Continuous
Maternal, Newborn & Infant Clinical Outcome Review Programme (MBBRACE)	Continuous
National Cardiac Arrest Audit (NCAA)	Continuous
National Cardiac Rehabilitation Audit	Continuous
National Chronic Obstructive Pulmonary Disease Audit Programme – Pulmonary Rehab	93% (97/104)
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	100% 79/79
Paediatric diabetes PREM survey 2015 (NPDA)	In progress
NPID National Pregnancy in diabetes audit	Continuous
NDFA: National Diabetes Foot Care Audit	Continuous
National Emergency Laparotomy Audit	Continuous
National Heart Failure Audit	Continuous
National Hip fractures Database including Falls and Fragility Fractures	Continuous
National Joint Registry (NJR)	Continuous
National Lung Cancer Audit (NLCA)	Continuous
National Prostate Cancer Audit	Continuous
National Vascular Registry	Continuous
Neonatal and Intensive Special Care (NNAP)	Continuous
Oesophago-gastric Cancer (NAOGC)	Continuous
Paediatric Asthma	100% (25/25)
Percutaneous Nephrolithotomy (PCNL) Audit	Continuous
Procedural Sedation in Adults (Care in Emergency	100% (50/50)

departments)	
Sentinel Stroke National Audit Programme (SSNAP)	Continuous
Stress Urinary Incontinence Audit	Continuous
UK Parkinson's Audit	Completed
Rheumatoid and early Inflammatory arthritis audit	In progress
Vital signs in children (Care in Emergency departments)	100% (50/50)
VTE risk in lower limb immobilisation (Care in Emergency departments)	100% (50/50)

In 2015/16 Bedford Hospital NHS Trust did not participate in 1 national audit for the following specific reason, identified in Table 3.

Table 3: Bedford Hospital NHS Trust non-participation in national clinical audits

National Audit	Reason
Community Acquired Pneumonia Audit (BTS)	Lack of resources

Table 4: National clinical audit reports received during 2015/16 with action taken/planned

National Audit	Actions

Use of Emergency Oxygen (BTS)	• Training being provided for medical and nursing staff on oxygen prescribing and the reaching and recording of patient target saturations :
	  ○ On induction
	  ○ Online
	  ○ At drop-in sessions

National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme – Pulmonary Rehabilitation	• Findings presented at Respiratory Study Day (April 2016) and Health and Wellbeing Day (April 2016) • Patient and Carers Information event planned for June 2016 to promote the service • Leaflets provided to GPs and local pharmacies • Bedford Rolling Programme offered to all referrals to ensure 100% of patients are enrolled within 3 months to start treatment • All patients offered Bedford programme for quick enrolment or Respiratory Exercise Group (REG) to support the patient whilst awaiting cohort programmes • Discussions planned with the team regarding the prescription of exercises/testing • Currently designing a programme for use in Bedford Prison

Procedural Sedation in the Emergency department (ED)	• Emergency department proforma updated as per national guidance and now includes a guidance section covering:
	  ○ Personnel present,
	  ○ ASA grading

	○ Level of sedation intended
National Audit of Inpatient Falls	• Falls assessment and care plan has been reviewed and amended in line with recommendations. • Reviewed assessment and care plan is being implemented alongside the Extramed project for electronic documentation. This has been piloted on a ward and will be rolled out in 2016/17. • Action plan with recommendations will be reported to quality board in Q1 2016/17.
End of Life Care – Dying in Hospital	• End of Life Champions to receive and disseminate key learning within clinical areas • Action plan and key points including Organisational Key Performance Indicators were taken to trust Board Autumn 2015 • Internal audits completed in year demonstrate improvements in End of life care

The Trust also submitted continuous data for 38 audits (including a patient experience survey) in Endoscopy throughout the year as part of the JAG (Joint Advisory Service) Accreditation incorporating the Endoscopy GRS requirements (Global Rating Scale)

Local audit

The reports of 74 local clinical audits 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 5).

Table 5: Local clinical audits and associated actions

Local Clinical Audit	Actions
Integrated Medicine	
Emergency Medicine	
DNACPR (Do not attempt cardio-pulmonary resuscitation)	• Project leader informed ward and/or medical staff of all DNACPR forms that had not been completed correctly • New combined TEP/ DNACPR and patient treatment options leaflet in pilot • Ongoing Basic Life Support/ILS and medical staff induction training • Joint working with primary care to encourage decision making before acute admission • Plan in place for annual re-audit
Respiratory	
Adult Community Acquired Pneumonia Audit (CAP)	• Findings discussed at departmental level and action taken to remedy shortfalls in practice • Improvements have already been noted with the introduction of

	revised CAP management guidelines which have been circulated, together with CAP antibiotic guidelines, to all junior and senior medical staff • This information is now being included in induction packs • Re-audit
Bronchoscopy practice (audit and re-audit)	• Introduction of two lists per week to ensure high risk patients are seen in a timely manner
Oncology	
Early Management of Oncology Patients Admitted with Febrile Neutropenia (audit and re-audit)	• Ongoing training sessions to include a session on Clinical Update days • PGD drafted – awaiting agreement • Appointment of additional Oncology consultants assists with education and training in the acute setting • Findings submitted and discussed at Anglia Cancer Network Oncology Group • Data for re-audit submitted April 2016 • Annual re-audit
All specialties	
Management of Hyponatraemia	• Local guidance developed • Poster displaying guidance in AAU and teaching provided to all AAU junior medical staff • Re-audit planned
Medicine - Ward round documentation	• A new proforma is being trialled by the endocrine team with a view to rolling this out across all the medical wards if it proves to be beneficial • Re-audit scheduled for April 2016
VTE RISK Assessment	• All VTE assessment entries on PIMS are recorded and shared with junior doctors and educational supervisors • Posters displayed on AAU and team aware that VTE risk assessment is monitored and results published monthly • VTE risk assessments per ward/ teams, both within 24 hours and after the first 24 hours, will be published daily and teams will be reminded to complete their risk assessment • 6 monthly trust-wide audit of percentage compliance with documented VTE risk assessment
Planned Care	
Anaesthetics	
Critical Care Complex (CCC) Chest Drain Insertion Audit	• Poster to be drawn up and displayed on CCC • A copy of poster and paper bundle attached to outside of each chest drain 'pack' in CCC chest drain draw • Re-audit
Painbuster - Audit of documentation	• To discuss with manufacturer regarding changing the tip colour • To change painbuster chart to incorporate place for manufacturer sticker to be placed • Update the Local Anaesthetic Infusion Chart to include a mandatory section in which the discontinuation of the infusion and removal of the device are documented

	• Painbuster guideline updated • Change MEDCHART prescriptions to protocol for ease of prescribing • Annual training/update nursing staff in the use of painbuster • PUMP training to all junior doctors on induction • Painbuster obsolete from September 2016- looking to purchase new device • Annual audit
T&O	
Orthopaedic Surgical Prophylaxis	• Update of antimicrobial guidelines • Re-audit
O&G	
Outpatient Novasure Endometrial Ablation	• Proforma for outpatient Novasure has been created recently with boxes for observations before and after procedure • Re-audit
GAP (Growth Assessment Protocol)	• To look into whether GROW training can be linked to WIRED • GAP project team established • Continuous monthly audits
Antenatal Audit	• Explore why CO2 test, the flu or pertussis vaccines are occasionally declined in pregnant women • If the flu vaccine is declined, revisit the reasons why, and consider re-signposting to encourage vaccine uptake • Re-audit
Routine Enquiry Audit - Maternity Services Bedford Hospital NHS Trust	• To consider a "prompt aid" in the notes. • Monthly audits until compliance achieved at 90% or above • Findings to be shared with maternity staff in the Maternity Team Brief • Continue to include routine enquiry in all Level 3 training and on maternity update weeks
Miscarriage Audit	• Review case notes of patients who had emergency surgery to identify specific risk factors • Annual re-audit
Care of Women with Previous Caesarean Section	• Review the Decision Tool to identify any barriers for non-usage • Decision Tool will be in the notes prior to initial consultation • ANC midwives to ensure all women are referral of woman to VBAC clinic • Documentation/discussion regarding use of syntocinon in labour with consultant • To audit the indication for ELCS for women who were assessed as suitable for VBAC • Meet with new doctors to inform of the VBAC pathway process • Annual re-audit
Neonates First Hour of Care	• Monthly ongoing audits • Teaching on both Neonatal Nursing Update and Midwifery Clinical Update which includes simulation sessions
Paediatrics	

Prolonged Jaundice Screening in Newborn Babies	• New guidelines being developed • Re-audit following introduction of guidelines
Paediatric Antimicrobial Audit	• Ongoing education • Paediatric Drug Chart to be reviewed to prompt recording of review/stop date and possibly indication • Re-audit
Essential Medical Surveillance of Children with Down's Syndrome (DS)	• To look into the setting up of dedicated DS clinics for essential medical surveillance for children with DS • Schedule of health check will be placed in the clinic rooms • To look into using the Down's Syndrome Medical Interest Group (DMSIG) schedule of health check as a checklist in the notes or incorporate the checklist into system One (IT) • To liaise with IT regarding incorporating the DS growth chart into System One
Feverish Illness in Children Audit	• Use of fever care pathway for assessing children presenting with fever • To redesign the clerking proforma to include all assessments to improve the triaging of patients • To improve documentation of care at home advice and safety netting • To provide advice leaflets to parents/carers • Re-audit
Audit on the Management of Babies of HIV Positive Mothers	• Continue to raise awareness of the HIV guideline • Hepatitis B vaccination to be offered • Identified the need to ensure consistency with blood tests – standard testing for full blood count, liver function test and urea and electrolytes • Follow-up proforma to be printed and filed in notes • BCG scar to be documented in the notes • Ensure appropriate follow-up • Follow up patients who do not attend appointments
Audit of Children with Coeliac Disease	• Joint Paediatric/Dietetic Coeliac Clinics set up June 2015 • Dietetic Coeliac Clinic runs bi-monthly so readily available slots for newly diagnosed patients
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 Disability within Bedford Hospital	• Continue use of the categories of reason for use of DNACPR • Develop clear identification on the form of the need for Mental Capacity Assessment and Best Interest decisions • Continue delivery of Mental Capacity Act Training • Re-audit

The reports of 4 local Patient experience surveys were reviewed by the Bedford Hospital NHS Trust in 2015/16 and the Trust intends to take the following actions to improve the quality of healthcare provided (Table 6).

Table 6: 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 COPD 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

National Confidential Enquiries

The national confidential enquiries that Bedford Hospital NHS Trust was eligible to participate in during 2015/16 are as follows:

- Mental Health
- Acute Pancreatitis
- Sepsis
- Gastrointestinal bleeding

The national clinical audits and national confidential enquiries that Bedford Hospital participated in, and for which data collection was completed during 2015/16, 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 (see Table 7)

Table 7: Bedford Hospital NHS Trust participation in national confidential enquiries

National Confidential Enquiry	Percentage participation
Acute Pancreatitis	60
Sepsis	80

Participation in clinical research

The number of patients receiving health services provided or sub-contracted by Bedford Hospital NHS Trust in 2015/16 that were recruited during that period to participate in research approved by a research ethics committee was 696. This includes both portfolio and non-portfolio studies. In addition to the above there are 267 patients in follow up process.

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

Bedford Hospital NHS Trust was involved in conducting 27 clinical research studies in Oncology, Ophthalmology, Cardiology, Haematology, Dermatology, Surgery, Midwifery, Paediatrics and Respiratory Medicine in 2015/16.

The improvement in patient health outcomes in Bedford Hospital NHS Trust demonstrates that a commitment to clinical research leads to better treatments for patients.

There were over 40 clinical staff participating in research approved by a research ethics committee at Bedford Hospital NHS Trust during 2015/16. These staff participated in research covering 10 medical specialties.

As well, in the last three years, 101 publications have resulted from our involvement in National Institute for Health Research (NIHR), which shows our commitment to transparency and desire to improve patient outcomes and experience across the NHS.

CQUIN Framework

A proportion of Bedford Hospital NHS Trust income in 2015/16 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 Commissioning for Quality and Innovation(CQUIN) payment framework. Further details of the agreed goals for 2015/16 and for the following 12 month period are available online at: https://www.innovation.nhs.uk/pg/cv_blog/content/view/40573/network

In 2015/16 five CQUINs applied to the Trust (listed in Table 8).

Three were mandated nationally:

- Acute Kidney Injury
- Sepsis
- Dementia
- Avoidable admissions

The remaining one was negotiated locally with Bedfordshire Clinical Commissioning Group:

- High Resource Patients

Table 8: Bedford Hospital NHS Trust achievement against 2015/16 CQUINs

Indicator identifier	Description	Overall Achievement of target (%) for 2015/16
1	Acute Kidney Injury	75%
2a	Sepsis Screening	75%
2b	Sepsis Antibiotic Administration	50% TBC
3a	Dementia Assessment	100%
3b	Dementia – Staff Training	50% TBC
3c	Dementia – Supporting Carer's	75% TBC
4a	Reducing the proportion of avoidable emergency admissions to hospital	0%
4b	Improving diagnosis and re-attendance rates of patients with mental health needs at A&E	0%

5	High Resource patients	100%

Care Quality Commission registration and compliance

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

Bedford Hospital NHS Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

Care Quality Commission has taken enforcement action against Bedford Hospital NHS Trust during 2015/16. Following a comprehensive inspection of the trust in December 2015 the CQC issued four requirement notices. Further details of the enforcement action taken are provided in Table 9.

The trust was rated as 'requires improvement' overall.

Figure 2: CQC ratings grid following December 2015 inspection

	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**

CQC's key findings were:

- Equipment was not always appropriately checked and maintained
- Nursing vacancy rates averaged 9.1 percent against a target of 5 percent
- Not all staff had completed mandatory training and some key groups of staff had not completed recommended training (e.g. Advanced Paediatric Life Support)
- The trust has governance processes in place to provide oversight of incident reporting and management, including categorisation of risk and harm. However, CQC was not assured that the trust demonstrated a sufficient depth of analysis or learning from incidents. As a result, CQC was not assured that improvement in practice to prevent recurrence had been achieved
- The trust did not have sufficient numbers of paediatric trained nurses in the paediatric department and emergency department
- When communicating decisions around Do No Attempt Cardio Pulmonary Resuscitation (DNACPR), staff did not always adequately assess patient's capacity to understand decisions

CQC provided some immediate feedback to the trust and the trust responded quickly and proportionately. For example, CQC raised concerns regarding access to the paediatric bays within the emergency department. The trust immediately installed a lock on dividing doors prior to installing a long-term solution of electronic, swipe card access doors, to ensure paediatric patients are treated in an area that is separate from the adult treatment bays.

Following a further unannounced inspection in early January 2016, CQC raised concerns regarding the staffing arrangements on the trust's paediatric ward not meeting the standards set by the Royal College of Nursing (RCN). In response, the trust implemented four hourly monitoring of patient numbers, patient acuity and nursing staff number to ensure staffing levels met demand.

In addition to the areas for improvement, CQC commended the trust in several areas including:

- Achievement of challenging A&E targets;
- Kind, caring and compassionate staff who treat patients with dignity and respect;
- The hospital is clean, hygienic and well maintained;
- Staff feel supported and have good morale;
- The trust achieved ratings of 'good' in four service areas (urgent and emergency services; medical care; critical care; and, end of life care); and

- The trust provides innovative surgical procedures (e.g. endovascular stent grafts and image guided endoscopy for sinus and skull base surgery) that have improved outcomes and patient safety.

Under the standard CQC inspection process, the trust was required to submit action plans detailing how it will address the four requirement notices, by when and the governance arrangements for monitoring progress. A summary of the action plans is provided in Table 9.

Table 9: CQC Requirement Notices

Regulation	How the regulation was not being met	Actions	Date completed/due date
Regulation 10 Dignity and respect	Patient's privacy and dignity was not always maintained at all times. For example, orthopaedic clinics that took place in 'over flow' areas including the breast clinics, meant that women were waiting for their consultation were seated wearing only a gown in an area shared with fully clothes men and women waiting for their orthopaedic clinic.	Review of waiting areas within Main Outpatients, identification of a private space to be used by patients attending the breast clinic should they wish to wait separately. All relevant staff informed of the provision and now offered to all patients attending breast clinic. The Planned Care division will review the scheduling of outpatient clinics to identify a better use of existing consultation and waiting spaces to minimise the risk of compromise privacy for patients.	March 2016 Summer 2016
	All reasonable efforts were not made to make sure that discussions about care and treatment only took place where they could be overheard. For example, in the emergency department and outpatient department, particularly phlebotomy.	Review of existing space within emergency department to identify a more suitable location for streaming of patients on arrival to the department. Improved sound proofing measures to interstitial doors between clinic rooms have been implemented. Review of phlebotomy clinic rooms to identify improvement options.	May 2016 May 2016 July 2016
	Patients did not always have privacy when they received treatment or when they used washing facilities. For example, on medical wards.	The Trust will re-launch its privacy campaign across all wards. This will include ensuring wards have sufficient privacy clips and other tools including hearing loops. The Trust will undertake an audit of washing facilities on wards to ensure locks and privacy curtains are in place.	Aug 2016
Regulation 11 Need for consent	Staff completing 'do not attempt cardio-pulmonary resuscitation' (DNACPR) forms did not comply with the Mental Capacity Act 2005 and the Code of Practice. Systems were not in place to assess, monitor and	DNACPR forms have been reviewed and amended to provide prompt to staff to undertake capacity assessment when determining who to inform of the decision not to resuscitate. The trust cardio pulmonary resuscitation policy has been reviewed and updated to include the role of capacity assessment in the	May 2016

	mitigate the risks relating to non-compliance with the Mental Capacity Act 2005. Sixteen out of the 32 DNACPR forms we reviewed stated that the patients did not have mental capacity. However, there was no evidence of mental capacity assessments being completed.	communication of DNACPR decisions. An education and awareness programme to ensure the responsibilities are embedded within relevant staff groups. Audits of completed DNACPR forms and patient notes to be undertaken in May 2016 and November 2016.	May 2016 November 2016
Regulation 17 Good Governance	Risks were not always identified and all mitigating action taken in all areas of the trust, particularly in maternity services.	Risk workshops for clinical staff within maternity and paediatrics departments led by the Risk and Patient Safety Manager. Recruitment of divisional risk and quality business partners and compliance facilitator to drive	April 2016 May 2016
	Patient records were not always accurately completed, including 'do not attempt cardio-pulmonary resuscitation' forms.	See section above in relation to DNACPR and mental capacity assessment.	May/June 2016
	Systems and processes were not always in place to ensure the documentation and monitoring of the cleanliness of equipment. This meant that staff were unable to identify if equipment had been cleaned or not, and therefore, there was a risk to the health and safety of patients using equipment.	Review and approve cleaning schedule for equipment, identify appropriate method to document equipment is clean and ready to use. Implement new process. Audit compliance.	End May 2016 July 2016
	Policies were not always comprehensive. For example, the safeguarding children policy and safeguarding adults' policy in place did not make reference to female genital mutilation or to patients admitted with mental health issues.	Develop a robust policy review process with divisions to ensure timely and appropriate review of policies. Trust safeguarding policy will be updated to include reference to FGM and mental health. FGM and mental health to be included within standard safeguarding training.	July 2016

Regulation 18 Staffing	Nurse staffing arrangements on the paediatric unit and emergency department were not sufficient to meet patient demand. The trust were on occasions understaffed according to their own agreed minimum staffing levels and regularly understaffed according to guidance published by the Royal College of Nursing in 2013. CQC raised concerns with the trust and it took immediate and appropriate action. However, CQC needs to ensure these actions are sustainable and that staffing levels within the paediatric unit are consistently sufficient to meet patient demand.	A bespoke A&E risk assessment tool will be developed with existing staffing reviews in place (three times daily through the Quality Operational meetings). Ward and departments are undergoing review as part of the 2016/17 budget setting process. Staffing on Riverbank Ward (paediatrics) is monitored every four hours and escalated accordingly. CNS time has been reviewed with time allocated to work within ward staffing numbers. Risk assessments are also reviewed every 24 hours by the Matron and Divisional Lead Nurse. An independent review of the ambulatory care model within paediatrics is scheduled for April 2016.	Jun 2016

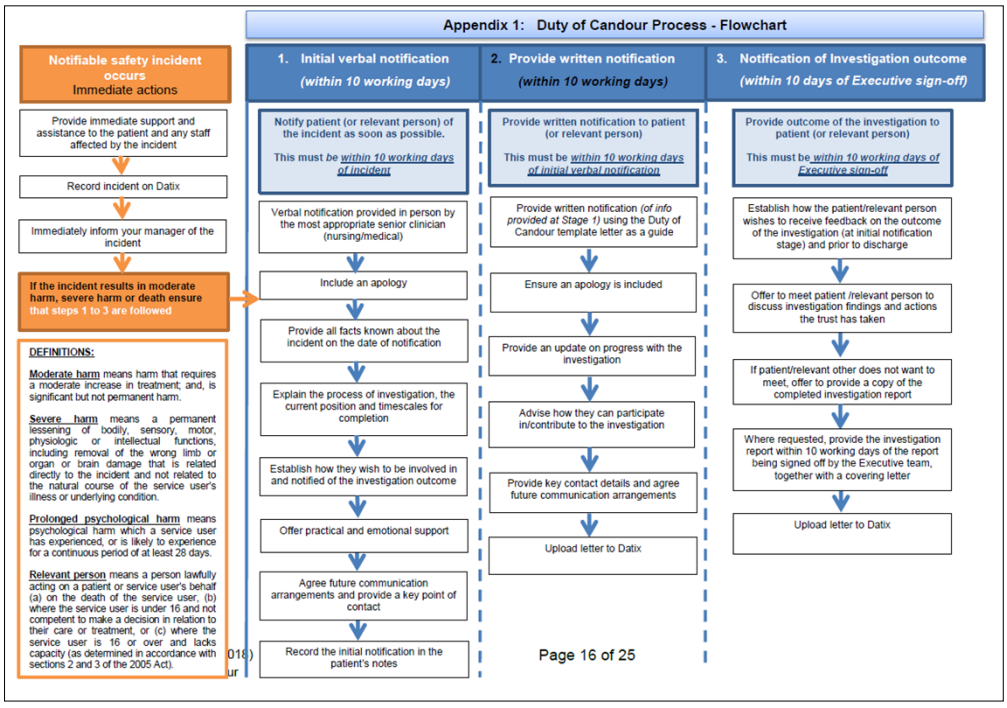
Duty of Candour

In November 2014, new legislation introduced a statutory duty of candour. Candour involves informing any person harmed through the provision of a healthcare service of the incident itself and offering an appropriate remedy, regardless of whether a complaint has been made or a question asked. The aim of this regulation is to ensure that providers are open and transparent with service users when things go wrong with their care and treatment.

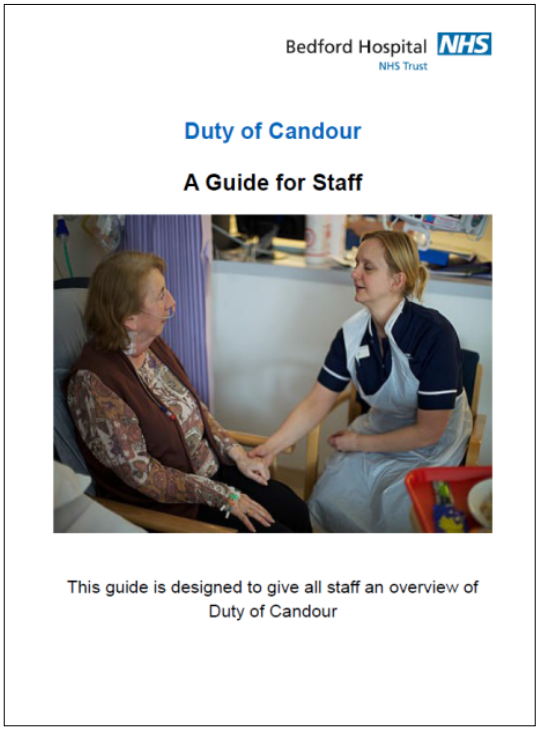
Health care providers must promote a culture that encourages candour, openness and honesty at all levels. This is an integral part of a safety culture that supports organisational and personal learning. Individual members of staff who are professionally registered are also separately subject to the professional duty of candour, which is overseen by the professional regulatory bodies such as the General Medical Council (GMC), Nursing and Midwifery Council (NMC) and the General Dental Council (GDC).

In order to deliver this legal requirement, the trust has an executive lead (Director of Nursing and Patient Services) with responsibility for Duty of Candour. In April 2015 the trust implemented its Duty of Candour Policy which supports a culture of openness and transparency. The policy is designed to ensure that staff understand statutory duty of candour and what incidents or circumstances it applies to. The policy contains a flow chart that guides staff on how and when duty of candour requirements apply (see Figure 3)

Figure 3: Duty of Candour flow chart



In addition, the trust has produced a booklet for staff which provides details on when duty of candour applies, what staff should do and what support they should offer their patients.



For serious incidents, the Trust maintains a Serious Incident (SI) log for monitoring progress with completing SI investigations and action plans. The SI log also contains a section for duty of candour compliance. This is monitored on an ongoing basis by the Risk and Patient Safety team and through the Serious Incident Review Panel (SIRP) which meets fortnightly to review progress with SI's. The Trust's Serious Incident (SI) investigation templates contain a section for completing duty of candour.

Duty of candour letters are uploaded onto the trust's Datix incident reporting system. For moderate incidents, the Trust's Datix system has been amended to allow staff to record that duty of candour has been completed for all patient incidents graded as moderate. A quarterly audit is undertaken by the Risk and Patient safety team on compliance with duty of candour for moderate and above incidents and feedback is provided to Quality Board. Duty of candour compliance is also a key quality metric on the Trust's Quality scored and compliance is monitored monthly. It also forms part of the Trust's monthly quality performance report to the CCG. When responding to complaints the principles of duty of candour are complied with, the response letters from the CEO 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.

NHS Staff Survey Results

The trust performed well in the 2015 NHS staff survey, with a score of 3.90 for overall staff engagement placing it in the top 20 percent of similar trusts.

Table 10: Bedford Hospital NHS Trust staff survey results 2015

Indicator	Bedford Hospital score 2015	Median national score 2015
KF21: % of staff believing the organisation provides equal opportunities for career progression/promotion	89%	87%
KF26: % of staff experiencing harassment, bullying or abuse from staff in the last 12 months	20% (top 20% of trusts)	26%

Sign Up To Safety

Patient safety improvement plan as part of Sign up to Safety Campaign (new)

Quality Improvement Strategy: Sign up to Safety Pledges

Put safety first. Commit to reduce avoidable harm in the NHS by half and make public our goals and plans developed locally.

>Progressively reduce avoidable harm. We commit to progressively supporting the development of safety projects that will;

- Improve our mortality rates to the top 25% of safest hospitals
- Increase the number of patients who receive harm free care to more than 95%
- 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%
- Reduce numbers of grade 2 pressure ulcers by 50%
- Eliminate all grade 3 pressure ulcers
- Reduce the numbers of patients who suffer harm from falls by 20%
- Zero avoidable VTE
- Improve discharge communication with the wider team

>Improve clinical systems

- A priority is to develop clinical information technology systems so they meet the needs of the user and contribute to safer practice and more effective communication.

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.

>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 so that patients and the public can see how we are performing in these areas on our website monthly. We 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% of staff have an appraisal in which goals are aligned with the trust's vision and values
- 95% 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

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.

> Be open and honest about patient safety issues and avoidable harms by;

- Sharing our Trust Board reports on our webpage and will pledge to develop further safety information about harm and mortality and make this available
- Continue to invite partners to participate in Internal Compliance Reviews
- Continue to implement the new duty of candour requirements and will review our approach to support staff to ensure that implementation is effective. Work with our key stakeholders to support internal and external surveillance of our performance on patient safety and quality
- Listen to and engage with our 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
- 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 our staff to speak up if they have any concerns about the quality and safety of patient care.

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

We will:

>Bedford Hospital pledges to be an active participant in regional and local safety collaborative to improve care. We will participate in regional and national quality and safety programmes to review and improve the care we give to patients. We will work with others to develop and improved understanding of measuring and monitoring safety and we will continue the collaborative and work with our commissioners and local Community Healthcare to reduce harm from pressure ulcers and supporting complex and discharges and acute care in community settings.

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

Support - help people understand why things go wrong and how to put them right.

>Develop our safety culture over the next three years. We will seek to ensure continuous quality improvement is a core value of the organisation and our staff. This means that our 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. We are committed to ensuring that our workforce has the capacity and capability to deliver quality improvement. We have started this work and have now recruited 'Safety Leads' and 'Safety Champions' who provide the driving force to improvements at a ward and team level. Our Safety Leads have the opportunity to report any challenges and seek support from Trust Board members. Safety Leads access Safety Development Programme which we have commissioned from the University of Bedford University. The Trust also seeks to understand Human Factor theory and embed this within our training programmes.

>Engaging with patients and staff to improve safety;

We are committed to the development of a safety improvement plan to support our Sign up to Safety pledges. Our actions include;

- We will develop Trustwide quality improvement capability approach that supports teams to lead and manage their own improvement work with focus on coaching in quality improvement methodology.
- 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 our Clinical Quality Strategy
- Ensure our staff understand their responsibilities for patient safety through our 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

Data Quality

Bedford Hospital NHS Trust submitted records during 2015/16 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:

Which included the patient's valid NHS Number was:

- 99.70% percent for admitted patient care;
- 99.22% percent for outpatient care; and
- 99.92% percent for accident and emergency care.

Which included the patient's valid General Practitioner Registration Code was:

- 99.95% percent for admitted patient care;
- 99.95% percent for outpatient care; and
- 99.94% percent for accident and emergency care.

Information Governance Toolkit

Bedford Hospital NHS Trust Information Governance Assessment Report overall score for 2015/16 was 68 percent and was graded Green (Achieved Attainment Level 2 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. [Confirm still the case]

Bedford Hospital was selected during 15/16 to take part in monitors reference cost audit, results of this are not yet known

IGT Clinical coding Audit undertaken in March 2016 attained a Level 2 for requirement 13-505 and Attainment Level 3 for requirement 13-510.

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

- Continued focus on Trust wide Data Quality Training
- Expansion of Data Quality Team to improve the wider Data Quality work streams , this includes:
    - Financial improvement project for clinical coding
    - Focus on Clinical Engagement
- Implementation of DATIX Mortality Module to enable electronic peer review process

Part 3: Overview of the quality of our care in 2015/16

Part 3 of the Quality Account presents data relating to national quality indicators. A quality indicator is a measure that can help inform providers of health care, 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 4.

Figure 4: The five Domains of the NHS Outcomes Framework

Domain 1	Preventing people from dying prematurely	Clinical effectiveness
Domain 2	Enhancing quality of life for people with long-term conditions	
Domain 3	Helping people to recover for episodes of ill health or following injury	
Domain 4	Ensuring that people have a positive experience of care	Patient experience
Domain 5	Treating and caring for people in a safe environment and protecting them from avoidable harm	Safety

Source: The NHS Outcomes Framework 2011/12

Our performance against 2015/16 quality indicators

Eight Quality Account indicators apply to Bedford Hospital NHS Trust in 2015/16:

- 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
- Emergency readmissions to the hospital within 28 days of discharge
- 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
- 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 the Health and Social Care Information Centre (HSCIC) with the first publication in October 2011.

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 Summary Hospital-Level Mortality indicator relates to two NHS Outcomes Framework Domains: 1. preventing people from dying prematurely; and 2. enhancing the quality of life for people with long-term conditions.

	2013/14	2014/15	2015/16
Bedford Hospital NHS Trust	110.07 Band 2 'As expected' 21.8% Palliative Care	108.7 Band 2 'As expected' 23.0% Palliative Care	0.989 Band 2 'As expected' 27.4% Palliative Care
England average	100.00	100.00	100.00
Best performing Trust	62.59 Band 3 'Lower than expected' 6.1% Palliative Care	59.7 Band 3 'Lower than expected' 0% Palliative Care	0.652 Band 3 'Lower than expected' 0.2% Palliative Care
Worst performing Trust	115.53 Band 1 'Higher than expected' 12.9% Palliative Care	119.8 Band 1 'Higher than expected' 32.2% Palliative Care	1.177 Band 1 'Higher than expected' 29.6% Palliative Care

Source: Health and Social Care Information Centre (https://indicators.ic.nhs.uk/webview)
Notes:
2013/14 data = July 2012 to June 2013 (published January 2014)
2014/15 data = October 2013 to September 2014 (published April 2015)
2015/16 data = October 2014 to September 2015 (published March 2016)

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:

- Continued review of all deaths via the Mortality Review Group
- Implementation of the Datix Mortality Module to further support the Mortality Review Group

Patient Reported Outcome Measures

Patient Reported Outcome Measures (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.

Patient Reported Outcome Measures for groin hernia surgery, varicose vein surgery, hip replacement surgery and knee replacement surgery relate to NHS Outcomes Framework Domain 3: helping people to recover from episodes of ill health or following injury.

Groin hernia surgery

The scores patients having undergone groin hernia surgery are based the responses to a standard measure of health questionnaire. This questionnaire covers five areas: mobility, self-care, usual activities, pain/discomfort and anxiety/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.

	2013/14	2014/15	2015/16
Bedford Hospital NHS Trust	0.087	0.069	0.078
England average	0.085	0.084	0.088
Best performing NHS Trust	0.132	0.154	0.135
Worst performing NHS Trust	0.008	0.000	0.008

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)

2013/14 = Final data (published August 2015) for period April 2013 to March 2014
2014/15 = Provisional 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

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

- The trust's score improved in 2015/16

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

- [To be inserted]

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.

	2013/14	2014/15	2015/16
Bedford Hospital NHS Trust	-7.53	-6.06	No score
England average	-8.70	-8.25	-8.99
Best performing NHS Trust	-14.62	-14.39	-13.14
Worst performing NHS Trust	11.23	5.59	-4.26

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)

2013/14 = Final data (published August 2015) for period April 2013 to March 2014
2014/15 = Provisional 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

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 between April 2015 and September 2015 because there were too few records to model (12 records)

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

- The Trust has identified the need to increase the distribution of post-operative questionnaires and improve the response. The Trust is working with its survey contractor to improve data capture in 2016/17.

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 laid out 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.

	2013/14	2014/15	2015/16
Bedford Hospital NHS Trust	20.23	21.56	No score
England average	21.38	21.44	22.09
Best performing NHS Trust	24.32	22.95	24.61
Worst performing NHS Trust	17.58	16.29	18.13

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

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

2013/14 = Final data (published August 2015) for period April 2013 to March 2014
2014/15 = Provisional 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

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

- The Trust did not receive PROM score for hip replacement surgery between April 2015 and September 2015 because there were too few records to model (12 records)

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

- The Trust has identified the need to increase the distribution of post-operative questionnaires and improve the response. The Trust is working with its survey contractor to improve data capture in 2016/17.

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.

	2013/14	2014/15	2015/16
Bedford Hospital NHS Trust	15.57	14.40	No score
England average	16.27	16.14	16.79
Best performing NHS Trust	19.03	18.48	19.34
Worst performing NHS Trust	12.33	11.48	12.40

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

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

2013/14 = Final data (published August 2015) for period April 2013 to March 2014
2014/15 = Provisional 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

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 has identified the need to increase the distribution of post-operative questionnaires and improve the response. The Trust is working with its survey contractor to improve data capture in 2016/17.

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 3: helping people to recover from episodes of ill health or following injury.

	2013/14	2014/15	2015/16
0 to 15 years of age	9.25%	6.9%	8.5%
16 years and over	11.14%	10.3%	10.7%

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

Notes:

2013/14 data = July 2012 to June 2013 (published January 2014)
There are no recent publications of 28 day readmissions – latest = 2011/12 standardised to 2007/8
2014/15 = data provided via CHKS source – Admitted patient care dataset
2015/16 = 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 and 2015/16 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 2015/16 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 4: ensuring people have a positive care experience.

	2013/14	2014/15	2015/16
Bedford Hospital NHS Trust	67.4%	73.3%	Not available
National average	68.7%	76.6%	Not available
Best performing Trust	84.2%	87.4%	Not available
Worst performing Trust	54.4%	67.4%	Not available

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

Note: Figures for 2012/13 differ from the data included in the 2013/14 Quality Account following the publication of the complete dataset covering years 2003/04 to 2013/14 in May 2014. Dataset is available to download via HSCIC.

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

- Data for 2015/16 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 2015/16 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 4: ensuring that people have a positive care experience.

	2013	2014	2015
Bedford Hospital NHS Trust	63%	75%	78%
National average	64%	67%	69%
Best performing Trust	89%	89%	89%
Worst performing Trust	40%	38%	46%

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:

- For the second year the trust's score have increased and is 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 to enable Trust leadership to be more responsive to staff needs and concerns.

Percentage of admitted patients who were risk assessed for venous thromboembolism

The percentage of admitted patient who were risk assessed for venous thromboembolism related to NHS Outcomes Framework Domain 5: 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; and
- 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; and
- people who are admitted to hospital because they have a diagnosis or signs and symptoms of deep vein thrombosis (DVT) or pulmonary embolism.

	2013/14	2014/15	2015/16
Bedford Hospital NHS Trust	95.9%	95.19%	95.16%
National average	95.7%	95.99%	Not Published
Best performing Trust	100%	100%	Not Published
Worst performing Trust	90.8%	88.46%	Not Published

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

2015/16 = not yet published nationally - published final outturn figure entered

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 due to a range of measures in place. This includes a patient safety programme dealing specifically with VTE and the introduction of e-Prescribing and Medicines Management (ePMA) that requires a VTE assessment before prescribing can commence.

Bedford Hospital NHS Trust has taken the following actions to improve the percentage, 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: 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 2 or over during the reporting period.

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

The following cases are excluded from the indicator:

- people under the age of two at the date the sample 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).

	2013/14	2014/15	2015/16
Bedford Hospital NHS Trust	9.1	10.9	17.8
National average	14.7	15.1	Not available
Best performing Trust	0	0	Not available
Worst performing Trust	37.1	62.2	Not available

2014/15 = updated from official website
2015/16 = Internal figures based on 23 reported / 129000 bed bays

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

- The trust did not meet its target of less than ten cases of *Clostridium difficile* in 2015/16. In September 2015 the trust reported a cluster of eight cases of *Clostridium difficile*. The ribotyping of the eight cases were different, indicating that the root case was not the same source.

However, the trust identified lapses in care in seven of the eight cases including:

- Delayed collection of specimens
- Delayed isolation of patients
- Patient receiving multiple antibiotics
- Patient not given full course of antibiotics

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

- Following the root cause analysis of the cluster of cases in September the trust identified lessons and implemented an action plan to deliver the associated recommendations:
  - 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
  - Implement safety huddles to improve communication of information
  - E-prescribing to enable 14 day course treatment for *C. difficile*

Rate of 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 5: treating and caring for people in a safe environment and protecting them from avoidable harm.

	2013/14	2014/15	2015/16
Bedford Hospital NHS Trust	25.8 incidents reported per 1000 bed days	34.21 incidents reported per 1000 bed days 0.32% resulting in severe harm 0.50% resulting in death	36.18 incidents reported per 1000 bed days 1.2% resulting in severe harm 0.6% resulting in death
National average	33.3 incidents per 1000 bed days	35.9 incidents reported per 1000 bed days 0.92% resulting in severe harm 0.18% resulting in death	39.29 incidents reported per 1000 bed days 0.3% resulting in severe harm 0.1% resulting in death
Best performing Trust	5.8 incidents reported per 1000 bed days	21.88 incidents reported per 1000 bed days 0% resulting in severe harm 0.2% resulting in death	18.07 incidents reported per 1000 bed days 1.60% resulting in severe harm 0.1% resulting in death
Worst performing Trust	74.9 incidents reported per 1000 bed days	35.3 incidents reported per 1000 bed days 2.3% resulting in severe	74.76 incidents reported per 1000 bed days 0.5% resulting in severe

		harm 0.8% resulting in death	harm 0.1% resulting in death

Source: National Reporting and Learning System (NRLS) (http://www.nrls.npsa.nhs.uk/resources/)
Notes:
2013/14 data covers period October 2013 – March 2014. These data were recalculated (previously reported as number of incidents per 100 admissions) and published in April 2015.
2014/15 data covers period April 2014 – September 2014

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

- The trust's performance is lower than the national average for the number of incidents per 1000 bed days and the percentage of incidents resulting in severe harm.

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

- The trust will continue to review patient deaths through its mortality review group;
- The trust's Governance worksteam to improve learning from incidents, never events and complaints

Summary of 2014/15

Bedfordshire and Milton Keynes Healthcare Review

Developing the plans for future sustainability

The Trust recognised in 2012 that under the current Foundation Trust framework it was not sustainable as a standalone organisation in its current form. In 2013 Monitor, NHS England and the Trust Development Authority commissioned McKinsey to undertake a review of the health economies in Bedfordshire and Milton Keynes which are financially both challenged.

The aim was to identify potential options for future sustainability for both areas. The review initially published its progress report in October 2014 and produced two potential models centred on either Bedford Hospital or Milton Keynes Hospital becoming a major emergency centre and the other an Integrated Care Centre. It recommended that both models required further work.

In early 2015/16 a third option was developed by Bedford Hospital and Bedfordshire CCG which provided an integrated option for future acute, community and primary care services and this model was accepted by regulators to be considered further alongside the original tow. In November 2015 a new joint programme was established across Bedfordshire and Milton Keynes with oversight from the tripartite regulators. This programme is reviewing the three potential options along with potential 'variants' to them with them aim of establishing a preferred option(s) to provide sustainable future hospital services across Bedfordshire and Milton Keynes. The outputs of the programme are expected to be a Pre-Consultation Business Case (PCBC) in summer 2016 leading to formal public consultation in late 2016 to early 2017.

Summary of Serious Incidents and Never Events in 2015/16

Serious Incidents in healthcare are relatively uncommon but when they occur, the NHS organisation have 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 2015/16

During the financial year 2015/16, the Trust declared a total of 55 Serious Incidents compared with 71 in 2014/15. A monthly breakdown of Serious Incidents is provided in Table 11.

Table 11: Serious Incidents by Month 2015/16

Month	Number of Serious Incidents
April 2015	10
May 2015	6
June 2015	7
July 2015	2
August 2015	8
September 2015	3
October 2015	4
November 2015	2
December 2015	2
January 2016	5
February 2016	3
March 2016	3
Total 2015/16	**55**

A breakdown of the categories of Serious Incidents that occurred in 2015/16 is presented in Table 12.

Table 12: Categories of Serious Incidents in 2015/16

Type of incident	Number of Serious incidents
Falls resulting in serious injury	11
Pressure Ulcers	6
Drug Incident	5
Unexpected neonatal death	4
Diagnostic incident including delay	4
Infection Control	4
Deteriorating patient/failure to rescue	2
Intra-uterine death (IUD)	2
Maternal death	1
Paediatric death	1
Never Event: Transfusion of incompatible blood	1
Never Event: Angioplasty incident	1
Complication post LSCS	1
Termination of Pregnancy (TOP) related incident	1
Critical care admission of gynae post-op patient	1
Air Embolism	2
Stroke post surgery	1
Unexpected death post laparoscopic surgery	1
Consent/MCA and surgery	1
Retained surgical drain (old)	1
Incorrect line insertion	1
Failure to act on abnormal test result	1
Viapath incident (lost block)	1
Information Governance breach	1
Total	55

Patient Falls

There were 11 serious incidents reported relating to patients sustaining severe harm following a fall. This compares to twelve incidents in financial year 2014/15. Of the 11 incidents, nine incidents related to patients sustaining a fractured neck of femur. Two of the incidents resulted in a patient sustaining an intra-cranial bleed.

As a result of these Serious Incidents, the Trust is undertaking the following:

- ✓ Review of the falls risk assessment and care plan to incorporate NICE Guidance CG161 recommendations and align it with the electronic care plan.
- ✓ Identifying and discussing patients at high risk of falls at the quality meeting each morning.
- ✓ Cohorting, specialling and implementing one to one nursing as required.
- ✓ Introduction of gripper socks as a top up item for adult acute inpatient wards
- ✓ Auditing of falls monitors and seat pad numbers and purchasing of additional sets as required.
- ✓ Additional low beds purchased – there are now 85 ultra low beds within the Trust.
- ✓ Introduction of the SAFER (**S**ight; **A**bility; **F**ootwear; **E**nvironment and **R**each) falls footprint which identifies 5 key actions all staff can complete to reduce the risk of falling in vulnerable patients.

Pressure Ulcers

In 2015/16, there were six avoidable grade three pressure ulcers declared (compared to 9 in the previous financial year). This is a further improvement on last's year's performance.

As a result of these Serious Incidents, the Trust is undertaking the following:

- ✓ Introducing new pressure reducing foam mattresses and dynamic mattresses
- ✓ Introduced new facial oxygen masks to reduce the risk of skin damage and trauma to patient's ears. The new masks allow for greater flexibility in the positioning of the elastic so that the elastic can be positioned under as well as over the ears. Nasal cannulae also now have foam protectors over the ears.
- ✓ Daily quality rounds by Matrons and ward managers continue to be undertaken;
- ✓ Introduction of devon boots as standard for all patients going to theatre for post recovery on Richard Wells ward.
- ✓ Reinforced education and training on undertaking and re-assessing patient's Waterlow scores and their correct calculation.
- ✓ Ongoing work in the development of a joint electronic wound care formulary with the community and Luton and Dunstable Hospital.
- ✓ Increased awareness and reporting of incidents by staff; this means that staff recognise the importance of appropriate skin checks from admission.
- ✓ The process for Root Cause Analysis has been strengthened and face to face review meetings implemented. Learning has been identified and shared through the development of internal Patient Safety Alerts and a monthly Quality Improvement Newsletter.
- ✓ Re-implementation and engagement of link nurses from all wards and departments

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 a low molecular weight heparin (LMWH) in a surgical patient
- Overdose of morphine to a child on a PCA (patient controlled analgesia) pump
- Omission of anti-epileptic medication (2 incidents)
- Incorrect prescribing of methotrexate (near miss)

As a result of these Serious Incidents, the Trust is undertaking the following:

- ✓ Updating of the WHO surgical safety checklist to ensure the prescribing of VTE prophylaxis is included
- ✓ Inclusion of VTE assessment and prescription on the vascular junior doctor induction
- ✓ Updated paediatric PCA guideline and update training for staff on new PCA pumps
- ✓ Access to summary care records now available in the ED Department to aid with timely medicines reconciliation
- ✓ Medicines Reconciliation Policy written and implemented.
- ✓ Re-education and awareness for staff on critical medicines through the display of posters; publication of an internal Patient Safety Alert on critical medicines, article in Medication Safety Newsletter etc.
- ✓ Junior doctor induction includes a session on prescribing of cytotoxic medication
- ✓ Medication safety group

Never Events

In 2015/16 the Trust reported two Never Events. One incident related to an incorrect angioplasty procedure being performed and the second incident related to the transfusion of ABO incompatible blood.

The following actions were implemented as a result:

Angioplasty Never Event:

- ✓ Introduction of an adapted version of the WHO safety checklist in Radiology
- ✓ Introduction of induction and competency checklists in radiology for locums in clinical modality
- ✓ Electronic ordering/e-request system now in place in Radiology to replace previous paper request cards
- ✓ Review and updating of local protocols and procedure in Radiology

Transfusion of incompatible blood:

- ✓ Blood transfusion training made mandatory for junior doctors at induction. Face to face training delivered plus completion of an e-training package.
- ✓ Ensuring that the group check policy (2 samples required) is followed prior to the issuing of blood components to minimise blood sampling errors
- ✓ The Trust is reviewing its systems for how blood transfusion training is recorded
- ✓ Dissemination of the learning to all staff through the Quality Improvement Newsletter; the Surgery and Anaesthetic quality group meeting; physicians meeting in Medicine; audit meeting case presentation and through the ward managers meeting.

Complaints, Patient Advice and Liaison Service and Complements

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

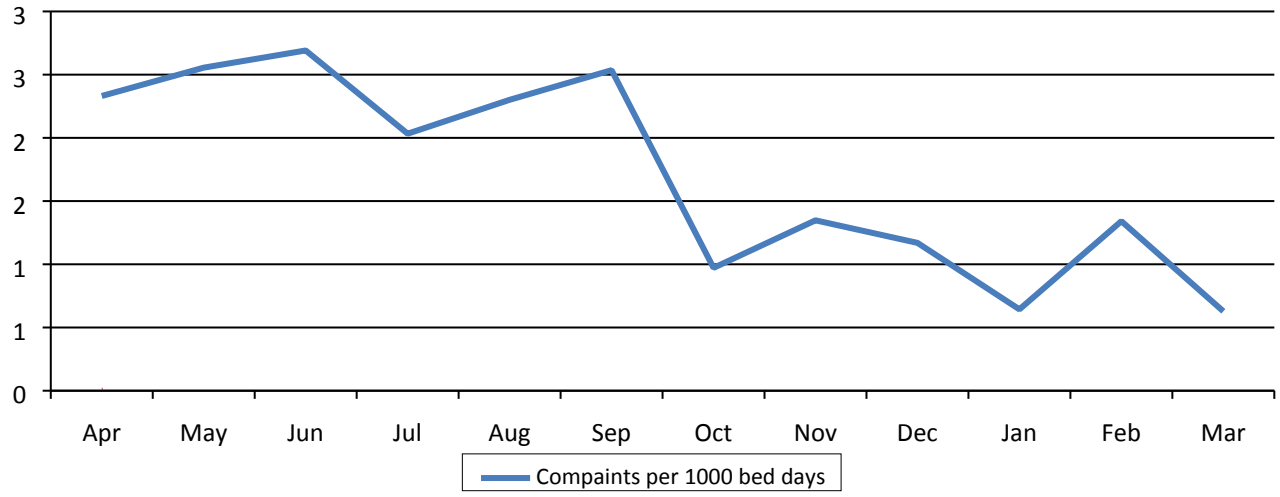
A formal complaint involves a thorough investigation and the Chief Executive responds directly to the complainant. When investigating a complaint we are guided by national requirements, we have a local target of 45 working days in which to complete an investigation and respond to the complainant.

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 (which may include, for example, 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). The PHSO will review the case using information we provide and consider further investigation and recommendations.

Figure 5 demonstrates the reduction in complaints over the past 12 months per 1000 bed days. The total number of complaints in 20115/16 was 252 compared to 303 in 2014/15, representing a decrease of 17 percent.

Figure 5: Complaints per 1000 bed days 2015/16



Complaints to the trust encompass a range of issues and individual complaints can pertain to a number of departments. In most cases, a complaint deals with more than one issue. The trust's complaints team logs every complaint and identifies the themes raised (see Table 13 for detailed breakdown of categories and the frequency these categories feature in complaints). The largest complaint category relates to all aspects of the clinical treatment experienced by a patient. This broad category can include patient dissatisfaction with the outcome of a procedure or treatment, or patient dissatisfaction with the treatment options offered. The second most frequent cause for complaint is poor communication, which may include issues such as staff failing to introduce themselves to patients, a failure to adequately communicate the prognosis of a condition and/or a patient's discharge arrangements.

Subjects by which complaints have been categorised have been updated in line with national reporting requirements. Some complaints have more than one subject, and hence the table below will total more than the total number of complaints.

Table 13: Complaint categories 2013/14 and 2014/15 and 2015/16

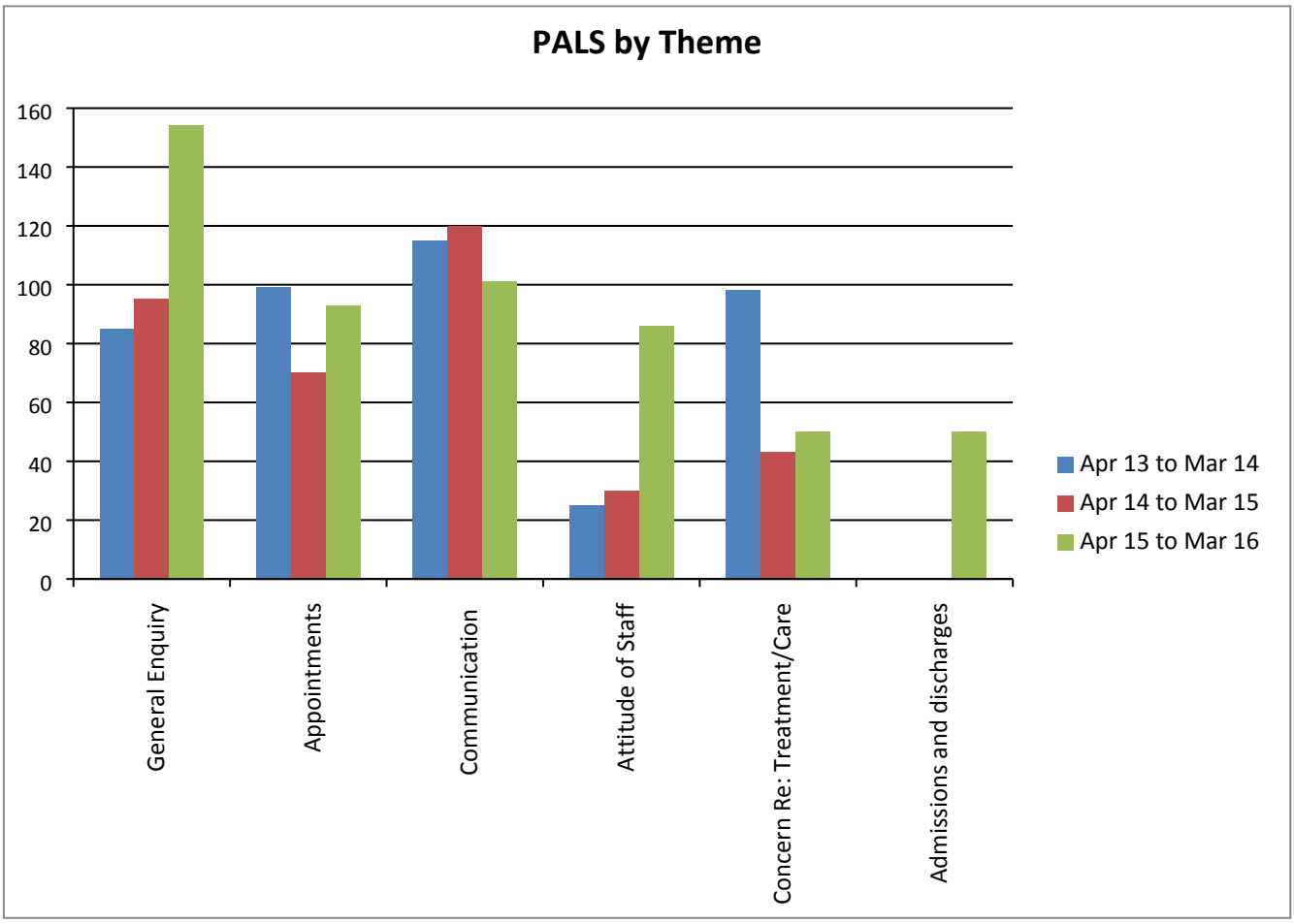
Category	2013/14	2014/15	2015/16
All Aspects of Clinical Treatment	158	268	119
Communication/information	76	111	66
Attitude of Staff	62	66	35
Admissions, discharge and transfer arrangements	38	47	21
Appointments, delay/cancellation (out-patient)	30	25	11

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 2015/16, the Trust recorded 782 formal PALS contacts (Figure 6 shows the top five categories for PALS contacts). These categories are largely consistent with previous years, although there were fewer contacts in relation to treatment and care.

Figure 6: Themes of formal PALS contacts in 2014/15 and 2015/16



In addition to formal PALS contacts, the Trust received 1636 informal contacts that are resolved immediately by the PALS team, such as provision of contact details for departments and 'signposting' for patients who are unsure of how to access or communicate with certain services.

Compliments

- ✓ The Trust is fortunate to receive a significant number of compliments, gifts and donations every year (figures for 2015/16 are provided in

Table 14). 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 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 condition with the recommended exercises
- ✓ Compliment regarding the care and treatment within the department in particular the nursing staff and the surgeon
- ✓ Excellent care and compassion
- ✓ Staff were caring and efficient
- ✓ Very helpful staff in outpatient

Table 14: Compliments, gifts and donations received by quarter during 2015/16

2015/16	Number of compliments
Q1	400
Q2	705
Q3	1045
Q4	1120
Total	**3270**

Bedford Hospital's response to *Complaints Matter* by the Care Quality Commission (CQC)

In December 2014, CQC published *Complaints Matter*s outlining its findings of an investigation in to how complaints are dealt with by hospitals. The report also detailed how complaints and a trust's response to complaints fit within its new regulatory model. Under the new inspection model, CQC review complaints and concerns with two aims:

- To improve how the trust uses the intelligence from concerns and complaints to better understand the quality of care provided; and
- To consider how well providers manage complaints and concerns to encourage improvement.

All complainants are sent a survey following receipt of the final complaint response letter. The result of these surveys are collated on a quarterly basis and reported to Quality Board. The overriding theme that complainants would like to see improve; is the time taken to receive a response, the team are working to achieve this by June 2016 to below 40 working days. The first step change to achieve this has been to reduce the number of formal complaints by early intervention from the PALS department and improved efficacy in dealing with informal contacts. The next step is to reduce the time for investigations to be completed.

Learning from complaints and PALS

During 2015/16 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.

Examples of changes made in 2015/16 as a result of complaints are:

- ✓ PALs opening hours have increased to 08.30 to 16.00hrs from November 2015 from previous opening times of 10.00 to 13.00 and 14.00 to 16.00hrs
- ✓ FFT results and comments made available to ward managers in an automatic weekly report to improve responsiveness
- ✓ Targeted training for staff using patient video stories have been implemented with very good feedback and better understanding from staff how the complainant felt
- ✓ A new policy to manage patients' property has been developed
- ✓ Improvements have been made to improve the experience of children in theatres using murals
- ✓ A new skin assessment tool is being developed to identify children at risk of developing pressure sores
- ✓ A number of personal amplifiers have been purchased through the hospital charity to improve communication with patients who are deaf or hard of hearing
- ✓ New placemats have been designed to provide patients with advice and information including; staff uniforms, protected mealtimes, visiting, ward rounds, discharge advice and staying safe in hospital; falls prevention, DVT prevention, medicines management.
- ✓ A dedicated email address is available for patients to send inquiries into the hospital; the emails are managed by switchboard staff and passed onto the appropriate service to answer.

Next steps

To reduce the target response time to below 40 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.

Critical Care Complex Peer Review

In October 2015 the trust's Critical Care Complex underwent a peer review by the East of England Critical Care Operational Delivery Network. Following the review, the trust received a very positive report which highlighted numerous strengths of the department, including:

- The positive and open attitude displayed by the team
- Effective team working
- Strong clinical engagement and effective clinical leadership
- Excellent ethos of multi-disciplinary working and collaborative approach to patient care
- Excellent feedback from patients and relatives
- Good follow up service that achieves good outcomes
- Excellent interaction with critical care course tutor at the University of Bedfordshire
- Good use of safety measures such as safety huddles, 'Fresh Eyes at 4' and display of safety thermometer data

The peer review also provided the trust with useful areas for improvement. The critical care department subsequently developed and implemented an action plan to implement these improvements.

Annex 1: Services provided by Bedford Hospital NHS Trust in 2014/15

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 Papworth Hospital NHS Foundation Trust
****** indicates a service provided by Patterson Healthcare

Annex 2: Statement from commissioners, healthwatch and overview and scrutiny committees

Bedfordshire Clinical Commissioning Group

Bedford Borough Council Adult Services and Health Overview and Scrutiny Committee

Healthwatch Bedford Borough

Annex 3: Statement of directors' responsibilities

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

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

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

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

By order of the Board

Chair: Date:

Chief Executive: Date:

Annex 4: External audit limited assurance report

Annex 5: 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
OBN	Oxfordshire Biosciences Network
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