

Report to Trust Board

Date May 26th 2010

Agenda item no 9.1

Title	Quality Account and Report (Consultation draft)
Author	Sue Blackley, Colin Ovington
Responsible Director	Director of Nursing & Medical Director
Purpose	Information
Action required	Board members are formally requested to read and comment on the content of the report
Executive Summary – The trust is formally required to publish a Quality Account detailing improvements on safety, patient experience and effectiveness of care from 2009/10 and proposed improvements during 2010/11. This report is subject to thirty days consultation and has been sent to the Overview and Scrutiny committee, LINK's and the PCT. Their formal responses to the report will be published within the body of report.	
Relevant CQC standard/ NHS Constitution pledge	All CQC standards
Link to strategy/plans	Improving the Patient Experience Strategy, Patient safety matters, Every infection matters, Governance and Risk strategy, Complaints policy
Impact assessment:	
- quality	DH require quality accounts to be published on an annual basis
- financial/business	Actively managing quality of services ensures safety for patient care and in addition the security and sustainability of business for the trust
- equality/diversity	All aspects of quality impact upon individual patients and is often dependent on a range of factors which are important for their cultural, privacy and dignity needs.
- risk	Managing quality improvement includes reducing risks for patients and the business of the trust
- legal/statutory	Report to be with the Department of Health by 30 th June 2010
- sustainability	None
Previous consultation/decision/discussion/	Quality account previously circulated to Board members in advance of the Board meeting in order to comply with the thirty day consultation period.

Date: 14th May 2010

QUALITY ACCOUNT

Draft for Consultation
April 2010
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Part 1: Statement on Quality from the Chief Executive

Every Patient Matters is our foremost strategy, knowing what patients experience, and feel about the care and treatment they receive is a key measure of how successful we are.

Listening and learning from their feedback is crucial, only by learning can we hope to make the improvements necessary to meet patients expectations.

Our aspiration to make every patient matter is a journey of continuous quality improvement. This is supported by commitments to safety, effectiveness and experience. The very nature of a quality account is to demonstrate a positive and purposeful approach about the quality of the services and care we provide within the hospital.

We work to build success in all we do and this requires us to embed the trust values in our everyday work. Our journey over the last year has seen our quality rating move from weak to good. This is the outcome of great dedication from the staff who strive to achieve high quality acute care for patients, as a core direction of the Trust.

This report details some of the key measures used to demonstrate the success of the last year and those where it is evident we have much more work to do on our quality journey.

Three key committees work towards achieving quality improvement

1. Patient Safety Committee
2. Improving the Patient Experience committee
3. Quality Performance Committee.

The output from their work is reviewed internally by the Governance Committee, and the Trust Board. All of this is performance monitored by NHS Bedfordshire through a quarterly review meeting.

Jean O'Callaghan
Chief Executive

Part 2: Priorities for Improvement 2010/11

Priorities for Improvement

The trust has considered its priorities for improvement by applying the following criteria: Measures that demonstrate the quality in services that:

- are priorities in the trust Business Plan: Vascular service; cardiac service; Bowel screening; Orthopaedic services and Stroke service.
- are areas of national concern and safety (e.g dementia care; cancer, hospital acquired infection; venous thromboembolism.)
- where local monitoring systems have highlighted areas of local concern such as reporting of patient experience, benchmarking our services with other hospitals or reporting adverse events.(e.g. patient information giving; pain service; inpatient mortality; management of the deteriorating patient ; discharge process; caesarean section rate)
- where the trust's performance in national studies have highlighted the need for improvement. e.g. cancer pathway; End of Life care
- where we have introduced new services and are being watchful of the quality.(e.g vascular services)

The trust has an additional priority – to provide assurance of the outcomes required by the registration requirements of the Care Quality Commission for their Essential Standards.

The trust has identified the following key priorities for improvement in 2010/11:

Patient Safety

- To have no hospital-acquired venous thromboembolism.
- To have no avoidable hospital-acquired *c. difficile* infection.
- To improve the Hospital Standardised Mortality Rate (HSMR), year on year,

Clinical Effectiveness

- To improve care for stroke patients
- To have no hospital acquired pressure ulcers

Patient Experience

- To Implement the trust Patient Experience Strategy
- To improve the patient rating of overall care and experience (in the national survey)
- To improve the care of the dying patient

2.1. Patient Safety

2.1.1. To have no avoidable hospital-acquired venous thromboembolism (VTE).

Description of issue and rational for prioritising

Venous Thromboembolism is a significant patient safety issue. The DoH estimates that 25,000 people in the UK die from preventable hospital-acquired venous thromboembolism (VTE) every year. This includes patients admitted to hospital for medical care and surgery. The inconsistent use of prophylactic measures for VTE in hospital patients has been widely reported. A UK survey suggested that 71% of patients assessed to be at medium or high risk of developing deep vein thrombosis did not receive any form of mechanical or pharmacological VTE prophylaxis.

Aim / Goal

No avoidable hospital-acquired venous thromboembolism during the year.

To establish the national risk-assessment process to ensure that all patients admitted to hospital are assessed for their thrombosis and bleeding risk on admission

To ensure that all appropriate patients receive chemical prophylaxis, mechanical prophylaxis, early mobilisation or a combination of all three.

Performance to be measured

	Target
Structure: The trust VTE Steering group is convened and meets at least four times in the year	100%
Process: All patients are assessed for VTE risk	100%
All patients will receive appropriate VTE prophylaxis	100%
Outcome: Hospital –acquired venous thromboembolism	0%

Current data: – data on current incidence is not available as HES data does not currently identify incidence of hospital-acquired VTE. To attain a picture of cases that were hospital- acquired as distinct from patients presenting with VTE requires internal clinical review of cases utilising the International Classification of Diseases (ICD10) codes I82.0-I82.9. National codes are being developed to capture this information

The Trust had adopted a policy in April 2009 to administer thromboprophylaxis to all patients unless contraindicated. The new DoH guidance required complete organisational change. A recent clinical audit of the risk assessment and prescribing of appropriate prophylaxis was undertaken to

- establish whether patients were being risk assessed in line with the new VTE guidance
- determine whether patients were receiving the appropriate prophylaxis
- establish the changes to practice required to comply with the new guidance

The results identified that 12/191 (6.2%) patients had evidence of documented risk assessment for VTE/bleeding risk, however 109/191 (57%) were receiving appropriate thromboprophylaxis.

Identified areas for improvement

Implementation of NICE CG92 – ‘Reducing the risk of venous thromboembolism in patients admitted to hospital’

VTE Steering Committee (operational since February 2010)

VTE and bleeding risk assessment procedures

Training for nursing staff on the correct measurement and fitting of anti-thromboembolic stockings

Patient information pre and post admission on the risks and treatment of VTE

New initiatives to be implemented during 2010/11

Introduction of an electronic risk assessment tool – this will enhance patient safety and enable data collection for the CQUIN framework

Introduction of revised admission documentation to support the VTE risk assessment

Introduction of revised drug charts to inform medical staff of the VTE risk assessment result and the appropriate prophylaxis prescription

Publicity campaign to inform all patients and staff on the implications of VTE, risk assessment processes and treatment plans

Revision of current VTE policy to comply with new recommendations

Monitoring and reporting of data in the monthly Patient Safety report presented to the Patient Safety Committee and Trust Board

Trustwide audit utilising NICE Guidance criteria to ensure best practice and compliance with local and national guidelines

2.1.2. To have no avoidable hospital-acquired *Clostridium difficile* infection

Description of the issue and rationale for prioritising

Patients continue to acquire *Clostridium difficile* infection in hospital even though the number is reducing. This infection is serious causing severe problems for patients and in 10% of cases may cause death.

Aim/Goal

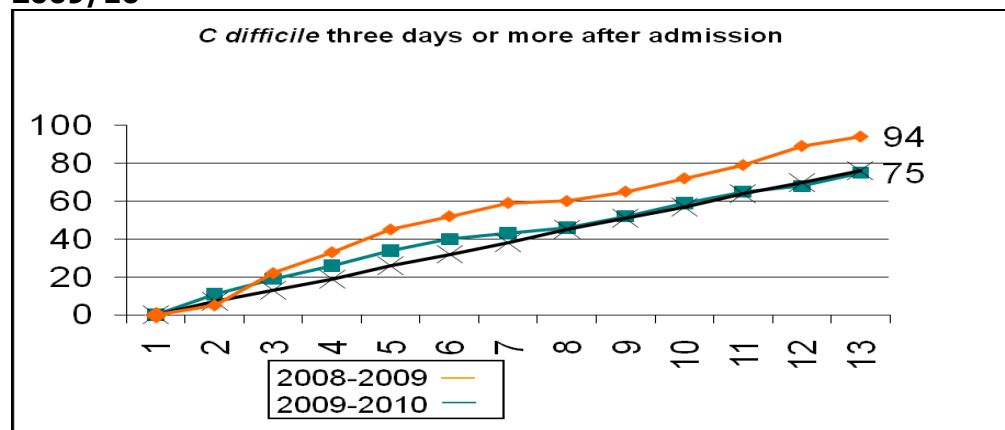
To reduce the number of patients who acquire *Clostridium difficile* while being cared for as an inpatient at the hospital.

Performance to be measured

	Target
Structure: Availability of cohort ward and isolation rooms	100%
Process: Patients requiring isolation for c.difficile are allocated an isolation bed within 2 hours of results	100%
Outcome: Hospital – acquired C.difficile infection	0%

(SHA /national benchmark target for 2009/10 is Less 25% < 56 infections)

2009/10



Identified areas for improvement during 2009/10

Clostridium difficile action plan for 2009/10 aims to reduce the number of hospital acquired infections by 20% compared to 2008/09

New initiatives to be implemented during 2010/11

To continue to reduce *Clostridium difficile* infections by working more closely with primary care to identify pathways of care and reducing or limiting antibiotic prescribing further. Our target is to reduce the number of patients acquiring the infection by an additional 25% (no more than 56 infections).

Quicker isolation of patients is an essential element of preventing the spread of this infection, and *Clostridium difficile* infection is a priority for use of isolation areas of the hospital.

2.1.3. To improve the Hospital Standardised Mortality Rate (HSMR).

Description of issue and rationale for prioritizing

Mortality is commonly used as the measure of clinical performance and of patient safety particularly when used to define how well individual types of surgery or other procedures are performed

Aim / Goal

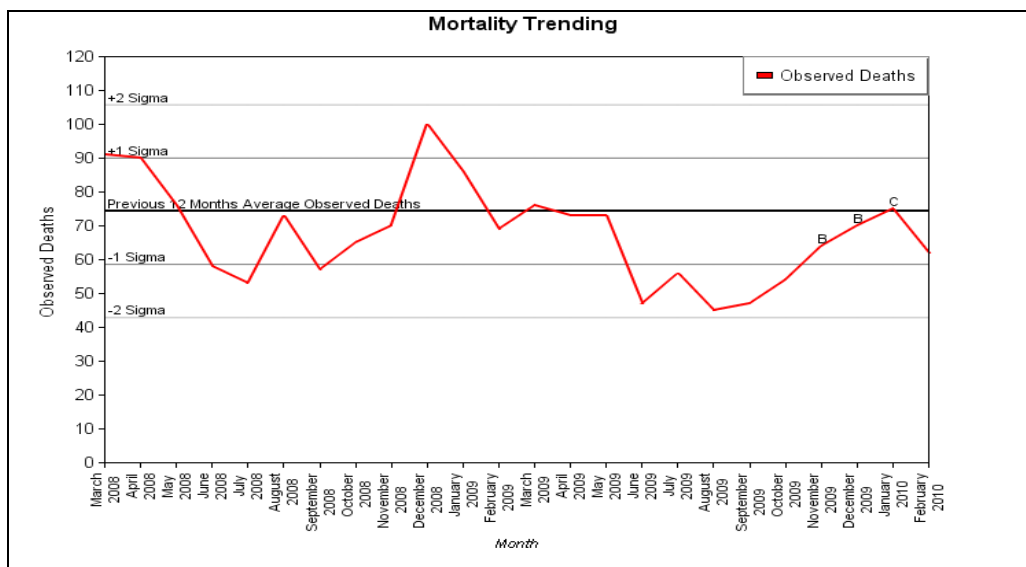
Reduce mortality rate using nationally recognised measure by 2% on 2009/10 baseline. CHKS data will be used until a nationally agreed measure is identified.

Performance

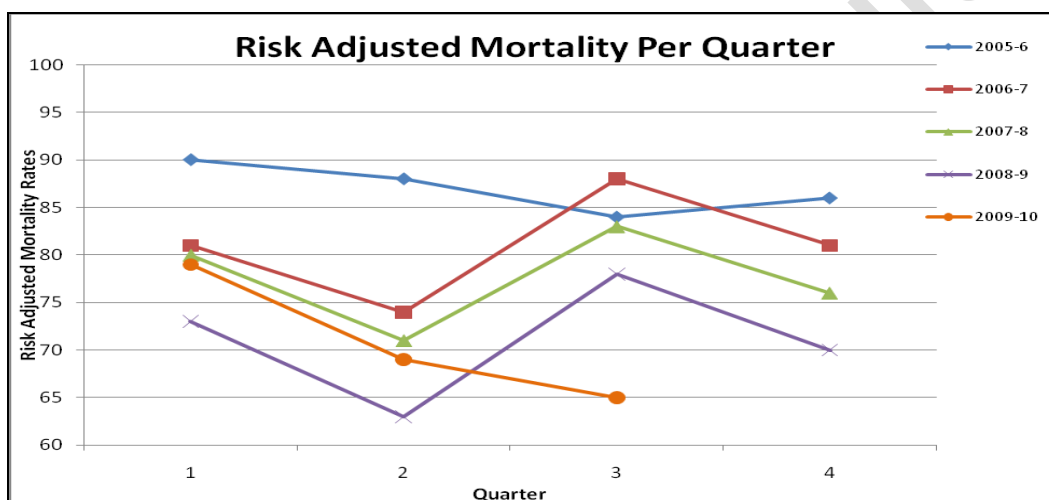
Outcome: Risk adjusted mortality rate

Target
2009/10 -
2%

The hospital uses risk-adjusted mortality data to assess mortality on a monthly basis. The graph below show the trend in Risk- adjusted mortality over the past year. The information is benchmarked against other trusts around an index of 100 and shows that over the past year the trust has had a rate that has been below the average rate of all trusts.



Year on year there has been a reduction in the risk adjusted mortality rate per quarter



Identified areas for improvement

The Patient at Risk team (PAR) began in earnest during 2009/10, visiting the very sickest of patients on wards, preventing unnecessary admission to critical care.

Use of the Global trigger tool (GTT) has helped identify where care and treatment could be improved to promote patient safety.

New initiatives to be implemented during 2010/11

Detailed project management to implement the national venous thromboembolism (VTE) assessment, which will help us identify patients who are most at risk of developing a blood clot prevent so that preventative strategies can be put into place.

Extend the hours of the Patient At Risk team (PAR) to provide continuous cover above the current 08.00 to 20.00 hours and at weekends.

Specialties are to reinvigorate the engagement of clinicians in the review of deaths to assure the data quality and identify any aspects of care for improvement.

2.2 Clinical Effectiveness

2.3.1. To improve care for stroke patients

Description of issue and rationale for prioritizing

The improvement in services and care for Stroke patients is a national priority, an East of England Region Pledge (5.3) and a key area for improvement in the trust business plan and where technological innovation can be implemented to improve the quality of care.

Aim / Goal

To reduce the time to wait for brain imaging to confirm ischaemic stroke.

To increase the number of patients with ischaemic stroke who receive thrombolysis.

To reduce the number of patients who are newly institutionalised after a hospital episode for stroke

Performance

Structure:	Patients with a stroke are cared for the specialized ward for 95% of their stay.	Target 85 %
Process:	Brain imaging to confirm ischaemic stroke is undertaken within <i>24 hours or 3 hours</i> of the onset of symptoms <i>for patients who meet the inclusion criteria for thrombolysis</i>	100%
	All patients who have confirmed ischaemic stroke and meet the inclusion criteria are offered thrombolysis	100%
Outcome:	Patients are not discharged to NHS institutional care / discharged back to their residence on admission	100%

Identified areas for improvement in 2009/10

Reduction in the time to wait for brain imaging

Increase the number of patients with ischaemic stroke who receive thrombolysis

To ensure that the number of patients newly institutionalized after a stroke is minimized.

New initiatives to be implemented during 2010/11

Clinics for patients who have had a "mini stroke" known as TIA (Transient Ischaemic attack) commenced in July 2009. This service will be developed and extended make it more effective for patients by raising the awareness of GP practices and ensuring speedier referral to this specialist service.

To improve the service so that acute stroke patients can have direct access from A&E to the stroke ward within 4 hours.

2.2.2. To have no hospital- acquired pressure ulcers

Description of the issue and rationale for prioritising

Pressure ulcers are avoidable, during 2010 the department of health have issued a nurse sensitive outcome indicator and a high impact action to help guide a reduction in pressure ulcers acquired in NHS provided care.

Aim/Goal

To achieve a 2% reduction in hospital-acquired pressure ulcers and a zero tolerance to hospital acquired grade 3 and 4 sores.

Performance

	Target
Structure: Staff are trained and aware of trust policy on the management of pressure area care	100%
Process: All patients will be assessed for risk of developing a pressure ulcer	100%
All patients will be given appropriate pressure – relieving mattresses	
Outcome: Avoidable Hospital –onset pressure ulcers	0%

Identified areas for improvement during 2009/10

Two part time nurses now deliver a tissue viability service to in patients at the hospital.
 Developed the systems to collect information about pressure ulcer incidence.
 Developed a strategy to reduce the incidence of pressure ulcers
 Improved the monthly reporting of statistics to the trust board.
 Better management of specialised pressure reducing mattresses on beds.

New initiatives to be implemented during 2010/11

Nurse sensitive outcome indicators and high impact action on 'Your skin matters' will be implemented and project managed.

2.3 Patient Experience

2.3.1 To implement the trust Patient Experience Strategy

Description of the issue and rationale for prioritising

The NHS Next Stage Review *High Quality Care For All* emphasises that if quality is at the heart of everything we do, it must be understood from the perspective of patients.

"Quality of care includes quality of caring. This means how personal care is - the compassion, dignity and respect with which patients are treated. It can only be improved by analysing and understanding patient satisfaction with their own experience."

Darzi, High Quality Care For All, June 2008

The trust has approved the Improving the Patient Experience Strategy which aims to ensure that the patient voice is heard; that feedback in all forms is encouraged and that we demonstrate genuine learning from listening.

The trust already has an established Improving the Patient Experience Committee (IPEC) to oversee patient involvement and for responding and reporting to the board on the issues raised in complaints and patient feedback.

Aim/Goal

To implement the trust *Improving the Patient Experience Strategy*.

- develop and annual improvement plan based on the strategy

To develop partnerships with patients and patient groups to understand the patient perspective through further development of IPEC and through the development of liaison with the newly formed Bedford LINKs

To improve our staff's confidence in involving patients and meeting their needs.
 To gain feedback from our patients in all forms
 To demonstrate learning from our patients' experiences

Performance

Patient satisfaction with the care we provide is an extremely important measure of our success or failure. Currently local surveys demonstrate that patients are generally happy with the care we provide, however the National Patient Survey gives contrasting results.

	Target
Structure: A trust forum for the discussion of patient experience is in place.	
Appropriate staff are identified and attend the first phase of the <i>Personal Best</i> ™ training	100%
Process: To offer the opportunity to every patient to give feedback on their experience of their care whilst in hospital	100%
No avoidable sharing of accommodation	100%
Patients are offered choice of menu for food	100%
Patients are given sufficient information about their care and treatment	100%
Patients report that their privacy and dignity is always respected	
Outcome: Trust demonstrates learning and improvement from patient experience initiative	
Performance in "Net promoted question" in CQUINs	> 90%

Identified areas for improvement during 2009/10

To target the lack of compassion, poor communication and bad attitude perceived by some of our patient feedback by the roll out of the training programme.

Process: To achieve performance above 82%

New initiatives to be implemented during 2010/11

Implement the customer care training programme *Personal Best*™ with a focus on shop window areas of the services provided

All in-house patient surveys will have the "net promoter" question, and surveys will be undertaken in a range of areas to include in and outpatient services.

2.3.2. To improve the patient rating of overall care and experience in the national Patient's Survey

Description of issue and rational for prioritizing

The National Inpatient Survey is the main source for reporting the perception of our patients and is used in the comparative performance tables and quality indicators- CQUINs. The most recent survey shows a fall in the patient satisfaction level. Also, in the past year, monthly in house surveys results have dipped to 75% on two occasions, the remainder of the year has been above the 82% benchmark and range up to 98%.

Aim / Goal

To increase the number of favourable responses from patients in response to the CQUINs questions:

Performance

National Survey questions	2008	2009
Were you involved as much as you wanted to be in decisions about your care and treatment?	52%	42%
Did you find someone on the hospital staff to talk to about your worries and fears?	38%	35%
Were you given enough privacy when discussing your condition and treatment?	70%	66%
Did a member of hospital staff tell you about medication side effects to watch for when you went home?	35%	28%
Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	67%	64%

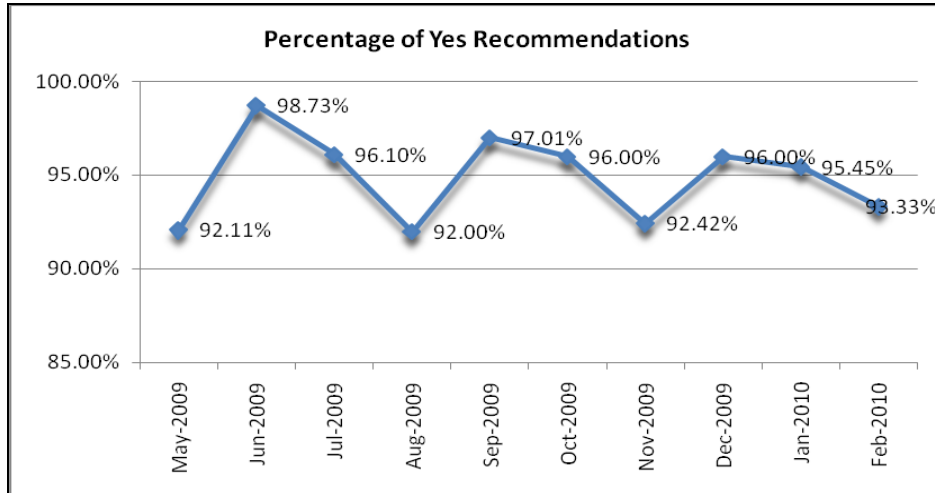
Performance to be measured

Structure:	Surveys are structured to ensure national survey questions are included	Target 100%
Process:	Patients report they were involved in decisions about their treatment / care	100%
	Hospital staff were available to talk about patient's worries / concerns?	100%
	Patients report they have enough privacy when discussing condition / treatment?	100%
	Patients are informed about medication side effects	100%
	Patients are informed about who to contact if they are worried about their condition after leaving hospital	100%
Outcome:	Patients report that they would recommend this hospital to their family and friends	100%
	Patients rate the quality of their care Excellent or Very good	90%

Performance 2009/10

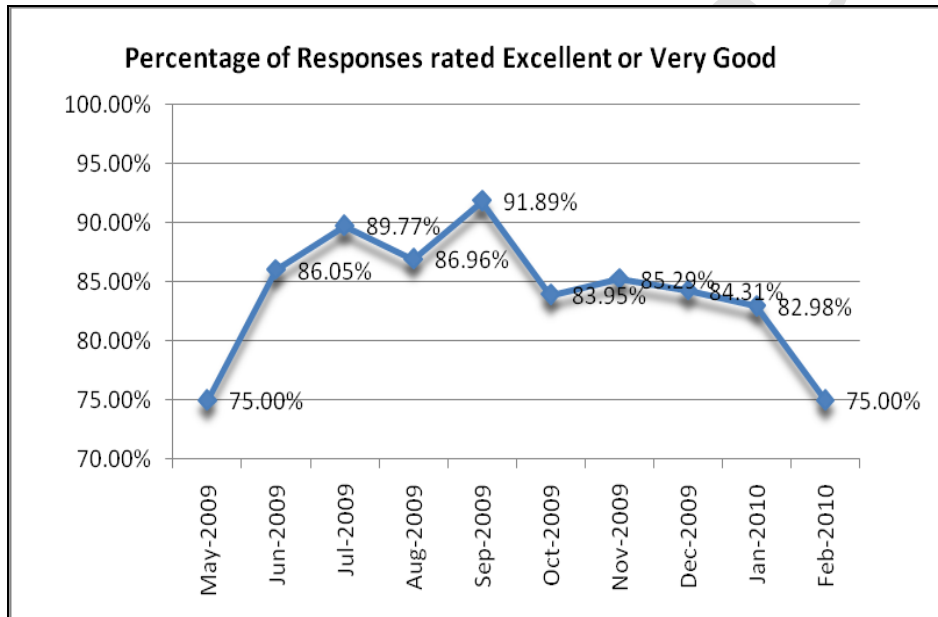
Would the patient recommend Bedford Hospital to a friend or relative?

(source: Trust Patient Satisfaction survey 2009/10)



Overall how would you rate the quality of your care?

(source: Trust Patient Satisfaction survey)



(Source National Inpatient Surveys)

Identified areas for improvement 2009/10

Any areas achieving less than 70% for rating the quality of care must identify possible causes and submit an action plan to the Quality Performance Committee.

Divisional Action Plans to improve patient information and communications.

New initiatives to be implemented during 2010/11

Include outpatient departments, radiology, pharmacy and A&E in the surveys.

2.3.3 To improve the care of the dying patient

Description of the issue and rationale for prioritising

50-60% of deaths currently occur in acute hospitals with patients experiencing an average of 18 days as an inpatient spread over 2-3 admissions in the last year of life.

Evidence from the National Audit Office shows that many people wish to be cared for and die in a location other than hospital (NOA 2008). The study found that in one locality, 40% of patients who died in hospital did not have medical needs which required them to be in an acute setting and could have been cared for elsewhere such as their own home or other appropriate setting (NOA; 2008b).

The NCEPOD study (National Confidential Enquiry into Patient Outcome and Death) report *Caring to the End 2009* found that nationally 50% of patients who die within 96 hours of admission can be identified on admission. Communication of that expectation of the outcome with the patient and relatives could be evidenced in only 19%.

The National End of Life Strategy (2009) aims to improve care in the last year of life and offer patients the choice of where they are cared for and where they die. The Liverpool Care Pathway (LCP) is a multidisciplinary care plan designed to emulate hospice care for use with patients in hospital. It comprises physical comfort; psychosocial and physical aspects of care; communication; information and care after death. The LCP was introduced in Bedford Hospital in 2004.

Aim/Goal

Allow patients to die in the place of their choice.

Partnership working to enable patients to die in the place of their choice ensuring whole health system approach to issue resolution, following a care plan with appropriate involvement from other organisations.

Performance to be measured

	Target
Structure: Healthcare workers caring for the dying patient and their relatives / carers are trained in the care of the dying e.g AGST	100%
All appropriate Wards use the Liverpool Care Pathway	100%
Process: LCP documents are completed	100%
Anticipatory prescribing for the key symptoms that may develop in the last days and hours of life is undertaken	100%
Outcome: The views of bereaved relatives and carers are sought	

Identified areas for improvement during 2009/10

In response to the National End of Life Care Audit, an End of Life Care Action plan has been agreed. Progress with this will be monitored .

New initiatives to be implemented during 2010/11

Improve the usage of Liverpool Care Pathway to improve patient and carer satisfaction with caring for the dying patient.

2.4 Statement of Assurance from the Board

2.4.1 Review of services

During 2009 /10 Bedford Hospital NHS Trust provided Acute NHS services. (See Appendix 1: Services Provided) The Trust has reviewed all data available to them on the quality of care in 100% of these NHS services. The income generated by the NHS services reviewed in 2009/10 represents 100% of the total income generated from the provision of NHS services by the Trust for 2009/10

2.4.2 The Review of data on the quality of services

Several sources of data have been reviewed:

- The Trust uses **CHKS benchmarking data in the Signpost system** to review performance in the quality of clinical care compared to Peers. This enables review of
 - **Patient safety**
 - Never events
 - In hospital falls
 - Surgical complications
 - Maternity care
 - Cancer services
 - Stroke
 - Orthopaedics
 - Other Specialty levels
 - **Clinical Effectiveness**
 - Mortality rates
 - Complications rates
 - ReadmissionsFor all specialities
- The Trust profile on the **Eastern Region Public Health Observatory (ERPHO) Quality Intelligence East (QIE)** site has been used to assess the trust position but was only of limited usefulness for the period under consideration in this report as it only covers the 2008/09 period)

2.4.3 The QIE Quality Profile shows the following trust performance to be Significantly worse within the Eastern Region on: (but more up-to-date data is now available)

Patient Safety

- Incidence of *clostridium difficile* – rate per 1000 bed days for acute bed days for acute specimens taken from patients aged 65 and over
- Incident of clostridium difficile – rate for 1000 bed days taken from patients aged two years and over
- Standardised Mortality rate (SMR) for congestive heart failure non hypertensive
- Standardised Mortality Rate (SMR) for pneumonia

Patient Effectiveness

- proportion of stroke patients given a brain scan within 24hrs of stroke
- proportion of stroke patients given aspirin or alternative e.g. clopidogrel within 48hrs of stroke
- proportion of stroke patients given a mood assessment
- Percentage of patients first seen by a specialist within two weeks when urgently referred with suspected breast cancer

- o percentage compliance with peer review by teams reports.

Patient Experience

- o Score for patients who were offered a choice of food
- o Score for patients who reported that they do not have to use the same bathroom or shower area as patients of the opposite sex
- o Score for patients who reported that when leaving hospital they were given written or printed information about what they should or should not do.

Current information for the trust gives a much improved performance – but is not available in benchmarked format.

2.4.4 Quality Risk Profile

- The **CQC's Quality Risk Profile** was used for the self assessment of performance leading into the application for registration with the CQC. Areas highlighted for improvement were:
 - o End of life care
 - o Management of self harm in A&E
 - o Safeguarding
 - o Completion of the implementation of certain NPSA alerts

2.4.5 Quality Metrics Overview

The quality information presented to the Trust Board is presented in a performance score card style. The Performance Report includes separate reports on Patient Safety, Patient Experience and Clinical Quality and highlights any positive or adverse trends to the board.

Table 1 below shows a summary of the Quality metrics reviewed by the trust over the past year

Table 1: Quality Overview: Performance against selected metrics

	Safety Measures	2009-10	2008-09	2007-08	Source of data
	% Hand hygiene compliance	95%	89%		<i>Trust HICT data</i>
	Clinical incidents reported: category major harm	8	5	5	<i>Trust Incident data</i>
	Serious untoward incidents reported to SHA	10	20	13	<i>Trust Patient Safety report</i>
	"never events" ** (serious) events that occurred within the Trust	0	1	0	<i>Trust Patient safety report</i>
	Patient falls from bed / trolley	90	82	85	<i>Trust Patient Safety report</i>
	Medication errors: Minor harm events	31	6	5	<i>Trust Patient Safety report</i>
	Moderate	4	0	0	<i>Trust Patient Safety report</i>
	Pressure ulcers- hospital acquired	79	156	-	<i>Trust Tissue Viability Service</i>
	Clinical Outcome measures	2009-10	2008-2009	2007-2008	
	Hospital Risk-adjusted mortality rates	65	84	92	CHKS information
	Readmission rate for surgery	3.5%	4.00%	3.90%	CHKS information
	Length of stay (average)	2.8 days	3	3.3	CHKS information
	Total Number of Fractured neck of femur	158	244	205	CHKS information
	Number with hip replacement HRG H86/H87	53	44	46	CHKS information
	Stroke				
	Stroke mortality (HRG A22 & A23)	14.35%	11.82%	17.37%	CHKS information
	Stroke mortality within 30 days of admission	86 (25 deaths)	123 (67 deaths)	119 (66 deaths)	CHKS information
	Readmissions	9.8%	8.4%	5.8%	CHKS information

Patient Experience Measures

		2009/10	2008/2009	2007/2008	National average 2009	Source of data
	Complaints received (total formal excluding PALS contacts) * under new Complaints system from 1.4.09)	* 182	119	90	n/a	Trust Complaints database
	Were you involved as much as you wanted to be in decisions about your care and treatment?	42%	52%	46%	53%	National Inpatient Survey
	Did you find someone on the hospital staff to talk to about your worries and fears?	35%	38%	32%	41%	National Inpatient Survey
	Were you given enough privacy when discussing your condition and treatment?	66%	70%	63%	71%	National Inpatient Survey
	Did a member of hospital staff tell you about medication side effects to watch for when you went home?	28%	35%	29%	36%	National Inpatient Survey
	Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	64%	67%	64%	70%	National Inpatient Survey
	% of patients who felt they were treated with dignity and respect	75%	75%	73%	80%	National Inpatient Survey
	% of patients who spent less than 4 hours waiting in A&E	33%	33%	27%	25%	National Inpatient Survey
	% Patients that would recommend the hospital to a friend / relative	86%	Not asked			Local Patient Survey

2.5 Participation in clinical audits

During 2009/10 23 national clinical audits and 4 national confidential enquiries covered the NHS services that the Trust provides.

During that period the Trust participated in 87% of national clinical audits and 100% of national confidential enquiries which it was eligible to participate in.

The national clinical audits and confidential enquiries that Bedford Hospital NHS Trust participated in during 2009/10, and for which data collection was completed during 2009/10, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry

Table 1 : LIST OF ELIGIBLE NATIONAL AUDITS and participation in 2009/10

The national clinical audits and national confidential enquiries that the Trust was eligible to participate in during 2009/10 are as follows:

Audit	Bedford Hospital Participation	Participation 2009/10 no of cases / no of registered cases required by the terms of the audit
Continuous, all patients		
National Neonatal Audit Programme (NNAP)	y	100% The information is taken directly from the data inputted into SEND (CALDICOTT Guardian has given permission for this) so it's done automatically. The Neonatal staff make sure that their data quality is 100%. This is checked daily. Exact numbers not known until report received.
National Diabetes Audit (NDA)	y	71 / * *All patients in hospital with diabetes during a one week period
ICNARC Case Mix Programme adult critical care units	y	TBC
National Elective Surgery PROMs: four operations	y	TBC
Congenital Heart Disease: paediatric cardiac surgery	No, n/a	
CEMACE: perinatal mortality	y	14/14 (100%) All relevant cases are submitted.
National Joint Registry: Hip, knee and ankle joint replacements	y	TBC
Renal Registry: renal replacement therapy	No, n/a	
NLCA: lung cancer	y	(MDT coordinator) TBC
NBOCAP: bowel cancer	y	546 / * submitted (?% TBC)
DAHNO: head and neck cancer	No,	(Luton submit data, not Bedford)
Adult cardiac surgery: CABG and valvular surgery	No, n/a	
MINAP (inc ambulance care): AMI and other ACS	y	100%
Heart Failure Audit	y	223 /223 (100%)
Pulmonary Hypertension Audit	No	
National Hip Fracture Database: Hip fracture	Y	96 submitted/ongoing (% TBC)
NAPTAD: anxiety and depression	No,n/a	
TARN: severe trauma	Y	No cases submitted (% eligible TBC)
NHS Blood & Transplant: intra-thoracic; liver; renal transplants	No	
NHS Blood & Transplant: potential donor audit	y	April 09-Sept 09 report only. Data input coordinated by the Transplant coordinator. Full year report not yet available from NHS B&T.
Adult cardiac interventions	(Y)	(when PCI starts)
Intermittent samples of Patients		
National Kidney Care Audit (2 days)	N/A	<i>This trust is not a haemodialysis centre</i>

National Sentinel Stroke Audit (n=40-60)	y	100% - Organisational module completed -(data collection October 2010)
National Audit of Dementia: dementia care (n=40)	Y	Ongoing / 40 requested
National Falls and Bone health Audit (n=60)	Y	To start September 2010
POMH: prescribing topics in mental health services	No, n/a	
National Comparative Audit of Blood Transfusion: changing topics	Y	100%
British Thoracic Society: respiratory diseases	No, n/a	
College of Emergency Medicine: pain in children, asthma, fracture	y	Asthma 50/50 100% #NOF 50/50 100% Pain – <i>no data submitted for this period</i>
One-off, all patients		
National Mastectomy and Breast Reconstruction Audit	y	65 cases submitted 100%
National Oesophago-gastric cancer audit	y	100% <i>Reported on a regional basis. This trust contributes to the upload by Addenbrooke's Hospital. Action Plan agreed on a regional basis</i>
RCP Continence Care Audit	y	40 / 40 , 100%

Table 2: Participation in National Confidential Enquiries

i.	The number of confidential enquiries in which we could have participated in 2009/10	4 NCEPOD 1 CMACE
ii.	The number if which we did participate	5
iii.	The names of the enquiries in which we participated	<ul style="list-style-type: none"> • Parenteral Nutrition • Emergency and Elective surgery in the Elderly • Surgery in Children • Peri-operative Care study • CEMACE
iv.	The number of cases for which data collection was completed and submitted to each audit as a percentage of the number required by the terms of the enquiry	Parenteral Nutrition 100% (11/11)
		Emergency and Elective Surgery in the Elderly Surgical Questionnaires: 88% (8/9) Anaesthetic Questionnaires: 55% (5/9)
		Surgery in children: 100% Nil return- Nil cases eligible to submit to study
		Peri-operative care: Data collection underway 67 cases submitted to date
		CEMACE: perinatal mortality 14/14 (100%) All relevant cases are submitted
v.	The number of national clinical audit reports that were reviewed by the provider during the reporting period	10
vi.	The actions they propose to take as a results of reviewing the reports of the enquiry to improve the quality of healthcare provided.	See below

The reports of 10 national clinical audits were reviewed by the provider in 2009/10 and the Bedford Hospital NHS Trust intends to take the following actions to improve the quality of healthcare provided – see table below

Table 3: Action in response to the recommendations of National Audits

BTS Adult Asthma audit	Local re-audit underway
National Comparative Audit of Blood Transfusion: Overnight Red Blood Cell transfusion	<p>Continue to highlight the risks of overnight transfusions in annual and at induction training:</p> <ul style="list-style-type: none"> • Patients without a clinical need should not be transfused overnight • Include guidelines for overnight transfusions in their Transfusion policy • Overnight transfusions should only be started if observations can be undertaken within 15 minutes of start time • The reason for transfusion, beneficial effects and adverse incidents must be documented in clinical notes
National Comparative Audit of Blood : Bedside transfusion re-audit	<ul style="list-style-type: none"> • All staff involved in transfusion to be competency assessed (NPSA SPN 14) • All staff involved in transfusion to receive annual mandatory and induction blood transfusion training • Staff questionnaire to ascertain reason for lack of observations being recorded • Discussions to take place at the Hospital Transfusion Committee with regard to patient placement on the ward during transfusion • Request made to Executive Management Group to extend nurse secondment
College of Emergency Medicine: Fractured neck of femur National Audit	<p>Documentation of pain score on arrival and re-evaluation after giving analgesia. Fast tracking of Fracture NOF, to improve time to X-ray and time to admission.</p>
Royal College of Physicians: Lung cancer Audit	<p>Use MDT meetings to capture all cases discussed, Try to record cases in real time or near real time. Liaise with pathology departments to correlate cases. Work with IT department to set up CSV file upload facility if information is collected on a third party system or identify resources to input data directly</p> <p>Use proforma for data collection at MDT. Identify key person to QA data prior to submission. Data inputters understand clinical implications of data. Map and allocate responsibility along patient pathway. Agree protocols and submission routes for patients that are treated across different organisations</p> <p>Refer to the document 14 key data items on the National Lung Cancer Audit Website and ensure that these fields are completed for all relevant cases. Assist MDT co-ordinator by chair ensuring that stage, performance status and other key fields are discussed and recorded for each patient</p> <p>Liaise with cancer waiting times team to identify lung cancer referrals. Liaise with radiology department to identify all imaging suspicious of lung cancer or mesothelioma. Liaise with pathology department to identify cases</p> <p>Ensure all histological diagnoses are submitted to the audit. Liaise with pathology department to identify cases. Review clinical diagnoses and diagnostics protocols if HCR is below optimum</p> <p>Review the specialist nurse service, ensuring all nursing posts are staffed and that clear referral pathways exist</p> <p>Review the specialist nurse service, allocate extra nursing support alongside lung cancer clinics</p> <p>Ensure that all surgical resections are submitted to the audit. If data is complete then review treatment policies for early stage lung cancer in patients with good performance status. Ensure that thoracic surgeon attends MDT meetings</p> <p>Ensure that all treatments are submitted to the audit. Review treatment policies for lung cancer patients</p> <p>Ensure that all treatments are submitted to the audit. Review treatment policies for small cell lung cancer patients</p>

National Bowel Cancer Audit	<p>Action Plan includes local action to ensure the audit data collected reflects the actual care process and the reported compliance better reflects the trust performance:</p> <ul style="list-style-type: none"> • Local action to ensure data on urgent cases are input • Enhance the data collection process on the level of Cancer Specialist Nurse input into patient care • Local action to ensure that preoperative radiotherapy data input to the audit reflects that on the cancer database. • Stoma formation and subsequent input from Cancer Specialist Nurse
National Care of the Dying Audit	<ul style="list-style-type: none"> ▪ The membership of the board includes an executive director with lead responsibility for care of the dying. ▪ The key performance indicators for care of the dying will be measured and reported as part of the corporate quality dashboard. ▪ Priority given in the Clinical Audit programme which includes an assessment of the views of bereaved carers. ▪ All health care workers caring for dying patients and their relatives/carers will have access to appropriate ongoing training and education in the care of the dying (DOH 2009) eg ACST
National Carotid Endarterectomy Audit	<p>Improved access to carotid Duplex</p> <p>Rapid referral from stroke service</p> <p>Next available vascular clinic (outpatients); review on day referral (inpatients)</p> <p>Ensure symptomatic patients are done on soonest available routine list or emergency list. <i>(N.B. data might be skewed because of asymptomatic patients who are not subject to same waiting times)</i></p> <p>·</p> <p>Increase access to urgent MRA/CTA, including out of hours</p> <p>Use of vascular scientist to ensure 100% compliance</p>
National Sentinel audit of stroke	<p>Specialist medical input with direct admission/early transfer to Acute Stroke Unit including direct admission to Stroke Unit from A&E</p> <p>Early detection and treatment of complications together with early rehab to reduce disability</p> <p>Introduce New TIA and Stroke clinics</p> <p>Improve Timely access to imaging - treatment depends on CT scanning which must be undertaken within 24 hours of the patient presenting at hospital. Carotid surgery for appropriate candidates</p> <p>Keeping patients and carers informed of diagnosis, treatment and progress and involving users in decision making</p> <p>Liaison with other services to provide seamless transfer of care</p> <p>Increased consultant and speech and language therapist input</p> <p>Appointment of a Stroke Specialist Nurse</p> <p>A new quiet room has been set up on the Stroke Unit as a TIA clinic to see those patients from A&E who need to be seen immediately, or patients on the Stroke Unit who are high risk but can be seen the next day</p> <p>Agreement has been reached whereby Radiology will allocate a slot each day for stroke patients</p>
National Organizational Audit of Vascular services	<p>Report received in March 2010 – action plan in preparation</p>

The reports of 105 local clinical audits were reviewed by the provider in 2009/10 and the Trust intends to take the following actions to improve the quality of healthcare provided [see table 5 for summary of action].

Table 4: Summary of Clinical Audit programme 2009/10

	Reason for Inclusion in Clinical Audit plan						TOTAL
	NHS LA (Clinical Risk management Standards)	NICE Guidance compliance	National Audits	PCT Quality contract requirement	Risk Management/Local Concern/Incident Follow-up	Other audits (includes compliance with alerts, prompted by CHKS benchmarking data, etc)	
Medicine	1	3	8	7	12	3	23
A&E	0	0	1	0	2	0	3
Diagnostics	0	1	2	0	1	0	4
Obs and Gynae	2	3	1	4	13	2	25
Paediatrics	2	2	2	4	7	1	18
Anaesthetics	0	0	0	0	8	0	8
Surgery	1	1	1	4	4	0	11
Urology	0	0	0	0	1	0	1
ENT	0	0	0	0	3	0	3
T&O	0	0	0	4	2	0	6
Nursing	0	0	0	1	2	0	3
							105

Table 5: Selected Findings and action from local audits

Clinical Audit	Findings	Action Recommended:
Management of Inpatients with Diabetes	<p>The findings of the audit revealed that, in general, diabetic patients were happy with their care; however a minority felt that some aspects of their management could be improved.</p> <p>Other points identified for improvement were :</p> <ul style="list-style-type: none"> improved management by better documentation Need to explain to patients if their usual regimen is changed Blood glucose monitoring is not being undertaken hourly Patients should be allowed to self medicate whenever possible Improved use of advice from the Diabetic Specialist Nurse 	<p>New Insulin prescription chart rolled out to all wards</p> <p>Training of clinical staff:</p> <ul style="list-style-type: none"> On the correct use and review of insulin sliding scales Hypoglycaemic guidelines Referral criteria for Diabetes Specialist Nurse Prescribing and administration of diabetes drugs <ul style="list-style-type: none"> Support patient self administration of diabetes drugs Staff knowledge survey to be sent out to assess training needs Implementation of the Think Glucose "Safer Use of Insulin Tool"
Prescriptions on Discharge (Quality of the "To Take Home / TTO" prescriptions included with the patient's discharge letter)	<p>50 - 60% of all TTOs had "events" which delayed screening for pharmacy staff. They included:</p> <ul style="list-style-type: none"> Clarifying duration of steroids and antibiotics Checking whether in-patient medications need to continue at discharge – eg: sufficient pain relief PRN ("As required") medications are often omitted from the TTO or mistakenly prescribed for regular use All changes to the TTO should also be reflected on drug chart. Eg: dose changes, additions and/or deletions At least 14 days supply should be supplied at 	<p>Ensure correct selection of medications from the Extra-med menus</p> <p>All prescriptions must be signed</p> <p>Handwritten changes should never be made</p> <p>Discharge Pharmacist has been appointed And Working closely with the discharge nurses</p> <p>If changes need to be made to a "locked" prescription, pharmacy should be contacted to unlock the prescription. However, doctors should not be locking the prescription</p>

	<p>discharge</p> <ul style="list-style-type: none"> Re-labelling required if doses have changed during admission 	<p>anyway. This should only be done by the pharmacy staff</p> <p>To continue the training session delivered by the Chief Pharmacist to Junior Doctors.</p> <p>Ongoing re-audit</p>
Compliance with the Trust Do not attempt Resuscitation (DNAR) Policy	<ul style="list-style-type: none"> DNAR forms are being used when a decision has been made (98%), and in the majority of cases the forms are filed in the correct place in the casenotes (85%) Decisions on patient DNAR status were made by an appropriate member of staff in 83% of cases but consultant review within 24 hours, where applicable, was only recorded as present in 28% - should the policy be amended to state review must occur within 3 days to allow for weekends/bank holidays? Involvement or attempts to discuss DNAR decisions with patients/carers is not always documented Patient information leaflets were not always immediately accessible on the wards Some staff still seem unaware of the existence of the leaflet Only 3/39 DNAR forms (8%) did not have all of the relevant sections completed 	<ul style="list-style-type: none"> Review of DNAR policy to be undertaken in 2010 Ongoing Cardiac Arrest audit will now capture data on appropriateness of arrest callout and findings will be fed back to the Resuscitation Committee Patient bedside information folders will include a copy of the DNAR information leaflet translated into different languages Ongoing Basic Life Support training now includes: <ul style="list-style-type: none"> Dissemination of the DNAR policy Correct completion of the DNAR order Raises awareness of patient information leaflets Re-audit
Fracture neck of Femur – management in A&E (College of Emergency medicine indicators)	<ul style="list-style-type: none"> Bedford Hospital has achieved much higher results compared to the National standards, especially in numbers admitted within specified time period, and are in the upper quartile in admissions and time of admission to surgery. Due to lack of fast tracking of fracture NOF, there is delay in time of arrival to X-ray (within one hour), also as the Orthopaedic doctors insist on clerking patients in Emergency Department, patients do not get transferred to orthopaedic wards, until they are in the last 4 hours of arrival to ED. 	<ul style="list-style-type: none"> Documentation of pain score on arrival and re-evaluation after giving analgesia Fast tracking of Fracture NOF, to improve time to X-ray and time to admission.
Venous Thrombo-embolism Risk (VTE)	<p>At Bedford Hospital we had adopted an Deep Vein Thrombosis prophylaxis “opt-out” policy which recommended that all patients would receive thromboprophylaxis unless contraindicated.</p> <p>A Trustwide audit of current compliance found in the sample audited:</p> <ul style="list-style-type: none"> a low rate of documented risk assessment (6.3%) but most appropriate patients (75%) patients receive venous thromboprophylaxis. 	<p>This Department of Health requirement for evidence of a risk assessment requires a complete organisational and cultural change for all clinical staff.</p> <p>To meet this challenge the Trust:</p> <ul style="list-style-type: none"> has formed a VTE Steering Committee, chaired by Dr John McNamara (Deputy Medical Director); is developing an e-risk assessment tool to be rolled out Trustwide, ensuring the mandatory risk assessment is user friendly and accurate; is amending the current drug chart to capture the assessed risk of the patient along with the recommended prophylaxis; has pledged to improve communication of thrombosis risk to our patients upon admission and discharge is striving for VTE Exemplar Status to demonstrate our commitment to the VTE Campaign.
Implementation of the WHO surgical checklist	<ul style="list-style-type: none"> Compliance with completion of certain parts of the checklist have not improved since the results in 2007 	<p>A new Safety Checklist that will replace the original site marking checklist in mid May 2009</p> <p>The Trust has signed up to use this new checklist</p>
Pain scoring and inpatient satisfaction with pain control	<ul style="list-style-type: none"> 20% of patients who had pain scores 2 or more had no action taken 95% surgical patients had regular analgesia prescribed 72% patients felt they were able to make an informed choice of their acute pain management 44% of elective patients received a pain management information leaflet. 	<ul style="list-style-type: none"> Improve availability of pain management leaflets for pre and post operative patients Provide pain score rulers to all nursing and support staff Investigate the feasibility of posters at each bed space “IN PAIN ASK FOR HELP” Encourage regular analgesia prescriptions and PRN breakthrough medication – pain ladder

<p>Chlamydia testing in Termination of Pregnancy (TOP) clinic</p>	<p>88% (567/647) patients in TOP clinic were screened for chlamydia. This information was obtained using the ICE system so represents the percentage of patients who had a sample processed by the laboratory.</p> <p>80% (16/20) positive results were documented as having been treated.</p> <p>The women are advised to attend the GUM clinic for contract tracing +/- treatment but only 50% (10/20) women attended.</p> <p>There was documentation to evidence that contraception had been discussed and that the use of additional barrier contraception to prevent infection had been advised in all cases. The nurses also give written leaflets.</p>	<p>Should women be texted with a number to contact in order to obtain their results? This has worked well in other settings but who would be responsible for doing this?</p> <p>Should the women all be treated at the GUM clinic? The general feeling was that the audit had already shown that only 50% women attend the GUM clinic so this would not be good idea.</p> <p>It was suggested that instead of prescribing doxycycline, which the women have to continue to take at home, it would be better to give a one-off dose of Azithromycin. This is however a more expensive option.</p> <p>The figure of 3.5% seems very low and raised the question of whether the screening process in microbiology is modern and accurate enough. Urine specimen samples are more accurate but take 2 weeks to get a result. It was suggested that if the referring GP could take a sample then by the time the woman came for her appointment the result would be available. The other issue pertaining to microbiology was that in 9 cases the HVS was received with no endocervical specimen and yet these are both sent in the same bag. How can 1 be received and not the other?</p> <p>It was suggested consulting and collaborating with the GUM clinic to devise a mechanism to improve attendance.</p>
<p>Management of Pregnancy sickness (Hyperemesis)</p>	<ul style="list-style-type: none"> • 37 patient attendances in 6 month period = 6.2 per month • Majority of patients presented at 7-9 weeks gestation (64%), were non-smoking(89%) and healthy(71%) • The majority were multiparous(59%) and 1/3 of them had previous pregnancy with hyperemesis. • Majority only have single admission (68%) • Majority have maximal urinary ketones on arrival (53%) • Majority spend up to 24-48 hours as an inpatient (61%) • Antiemetic treatment did not follow local guidelines in 32% of cases • 96% of patients did not have any thromboprophylaxis • BMI was not documented in 93% of cases • Local guidelines do not implement non-pharmacological treatments suggested by NICE 	<ul style="list-style-type: none"> • Need for clear and complete documentation at all times • Need for weight not BMI on admission, daily weight • Need to clarify the use of other anti-emetics such as Cyclizine, Domperidone, Ondansetron etc. • Choice of pharmacological treatments to follow local guidelines unless clinically inappropriate • Guidelines to be clarified as to DVT risk assessment and indications for TEDS/LMWH in inpatients with Hyperemesis Gravidarum • Prompt commencement of therapy may reduce number of patients requiring single overnight stay => Day treatment where possible • Review of local guidelines to include non pharmacological measures recommended by NICE (patient advice literature to include ginger and acupuncture as well as dietary advice) • Combination of oral TTA medication and written patient advice may allow increased patient autonomy and reduce repeat admissions i.e. "self help" suggested by NICE • To use the 'Blooming Marvellous' leaflets that are given to mothers with their care plan. These leaflets include suggestions on eating ginger to reduce symptoms of nausea
<p>Safeguarding Children and young people – audit of documentation</p>	<p>Main recommendations from audit report, which found improvement in most criteria since last audit:</p> <p>The Safeguarding checklist needs to be improved with regard to the contents, which needs to link the antenatal and paediatric concerns</p>	<p>The Safeguarding team to set up a system so that an e-mail can be sent to request confirmation that a referral has been received by Social Services</p> <p>A Liaison post is to be appointed, whose role will be to carry out checks by contacting other Trusts and ensure all correct pathways have been followed e.g. follow-up on referrals</p> <p>Amendments to the Trust DNA Policy are to be made to ensure that if children about whom there are safeguarding concerns DNA an appointment then the GP/Social Services are alerted</p>

2.6 Participation in Clinical Research:

The number of patients receiving NHS services provided by the Trust in 2009/10 that were recruited during that period to participate in research approved by a research ethics committee was 1614 . (This trust recruited the most patients in the region for Tracheostomy Management in critical care -909 patients)

This increasing level of participation demonstrates the Trust's commitment to improving the quality of care we offer and to making a contribution to wider health improvement. The Trust was involved in conducting 72 clinical research studies. (of which 51 clinical trials NIFIR) .

The Trust completed 15% of these studies as designed within the agreed time and to the agreed recruitment target. The Trust used national systems to manage the studies in proportion to risk.

Of the 72 studies given permission to start,

100% were given permission by an authorised person less than 30 days from receipt of a valid complete application.

100% of the studies were established and managed under national model agreements and

20% of the 72 eligible research involved used a Research Passport.

In 2009/10 the National Institute for Health Research supported 51 of these studies through its research networks.

In the last three years, 131 publications have resulted from our involvement in NIHR research, helping to improve patient outcomes and experience across the NHS.

Draft for Consultation

2.7 Goals agreed with Commissioners

Use of the CQUIN Payment Framework: A proportion of the Bedford Hospital NHS Trust's income in 2009/10 was conditional on achieving quality improvement and innovation goals agreed between the Trust and NHS Bedfordshire, for the provision of NHS services, through the Commissioning, Quality and Innovation (CQUIN) payment framework. Further details for 2009/10 are available from www.bedfordhospital.nhs.uk

CQUIN Goals

The goals agreed with the commissioner for 2009/10

2009/10 is the first year of CQUIN goals agreed with the commissioner. Indicators and criteria were agreed against the three domains of quality ie safety, effectiveness and experience, and an additional domain for innovation. These areas also deliver regional pledges for improvements. Progress has been made on all indicators and some have been established as the first year of a longer programme of development and improvements in quality.

List of CQUIN indicators agreed for 2009/10

Domain - Safety
Reduce standardised mortality rate to less than 100
Reduce unadjusted mortality rate by 20 to 105 from 2008/09 baseline
Reduce 30 day mortality in patients with stroke by 2 to 10 5 from 2008/09
Reduce inpatient mortality rate after Myocardial infarction by 2 to 10% from 2009/10
Establish venous thromboembolism assessment
Undertake 100% MRSA screening of emergency admissions
Provide MRSA decolonisation for patients who are screened and found positive
Reduce Clostridium difficile cases

Domain - Effectiveness
Increase referrals from hospital to stop smoking services
Improve data collection on stroke patients
Undertake brain imaging within 24 hours of patients being diagnosed with a stroke
Brain imaging within one hour of stroke diagnosis if eligible for thrombolysis
Thrombolyse 80 to 100% of patients who are eligible for the treatment
Improve the percentage of patients who have had a stroke, who are cared for on the stroke ward
Anonymous data collection on breast feeding initiation, smoking status at delivery and early access
Meet the early access target for pregnant women
Reduce prevalence of smoking at delivery
Improve the percentage of women who initiate breast feeding
Register with the Trauma and Audit Network and Hip fracture database
Set processes to routinely collect data for Patient Related Outcome Measures (PROM)

Domain - Experience
10 to 20% increase in the number of internal inpatient surveys conducted
More than 60% of patients say that they would recommend Bedford hospital to a friend or relative
Improve the percentage of patients who rate the overall quality of care as good or excellent

Domain - Innovation
Review 20 sets of case notes every month using the global trigger tool
Increase the number of patients who are assessed by critical care outreach prior to admission to ICU

2.8 What others say about Bedford Hospital NHS Trust

Statements from the CQC

The Trust is required to register with the Care Quality Commission and its current registration status is unconditional as of 31 March 2010.

The Care Quality Commission has not taken enforcement action against the Trust during 2009/10.

2.9 Data Quality

Submitted records 2009/10

The Trust submitted records during 2009/10 by 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 patients valid NHS Number was:

98.4% for Admitted Patient care (853/52136)

98.1% for Outpatient care (4779/251225)

84.7% for Accident and emergency (9921/64613)

The percentage of records in the published data, which included the patients valid General Medical Practice:

98.2% for Admitted Patient care (952)

99.1% for Outpatient care (2455)

95.2% for Accident and Emergency (3127)

The Trust's score for 2009/10 for Information Quality and Records Management, assessed using the Information Governance Toolkit was 66 % (Amber)

The Trust was subject to the Payments by Results clinical coding audit during the 2009/10 period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnosis and treatment coding (clinical coding) were 5.3%.

The following excerpt is from the external audit of **Payment By Results (PbR) clinical coding audit results**: "The Trust is performing excellently compared to the overall performance of trusts in 2008/09.

The Trust's HRG error rate has improved since last year's audit, when the error rate was 5.3 per cent. This year the Trust's HRG error rate is 4.7 per cent and the Trust is taking forward the recommendations and areas of improvement from our 2008/09 review, with all but two recommendations completed. The national average in 2008/09 was 8.1 per cent and our Strategic Health Authority (SHA) average error rate in 2008/09 was 5.2 per cent. The financial value of the total or gross errors found is £6,934 from an audit sample of £345,677. The net impact of this means that the Trust

is overcharged commissioners by £2,226 or 0.6 per cent on the sample payments tested.

The HRG error rate is used as the main measure to compare trusts because HRGs drive payment under PbR. However, the HRG error rate does not always directly reflect the overall coding accuracy which underpins HRG assignment. The best indication of coding accuracy is the clinical coding data quality at a trust and this is measured by procedure and diagnosis error rates.

Clinical coding error at Bedford Hospital NHS Trust is substantially lower than the 2008/09 national average of 12.8 per cent. This year we audited 1,093 diagnoses and procedures. There were just 70 (6.4 per cent) errors, the majority of which were coder errors.”

Draft for Consultation

3.1 Looking Back- Review of quality performance 2009/10

Services identified for improvement in 2009/2010 Quality Report:

1. Patient Safety

- i. to further reduce MRSA blood stream infection cases
- ii. meet agreed targets for the reduction of clostridium difficile
- iii. demonstrate improvements in key quality indicators
 - achieve a year on year reduction in mortality rate
 - To achieve a reduction in patient falls
 - To achieve a reduction in pressure ulcers
 - To achieve a reduction in medication errors

2. Patient Experience

- i. to achieve improvement in what patients tell us about our services and care through the national patient survey
- ii. to establish liaison with the newly formed LINK organisation

3. Effectiveness

- i. Stroke
- ii. Introduction of new procedure Endovascular Aneurysm Repair

3.1.1. Patient Safety 2009/10

3.1.1.1. Meet agreed targets for reduction of *C. difficile* and MRSA blood stream infections

Description of Issue and Rationale for Prioritising

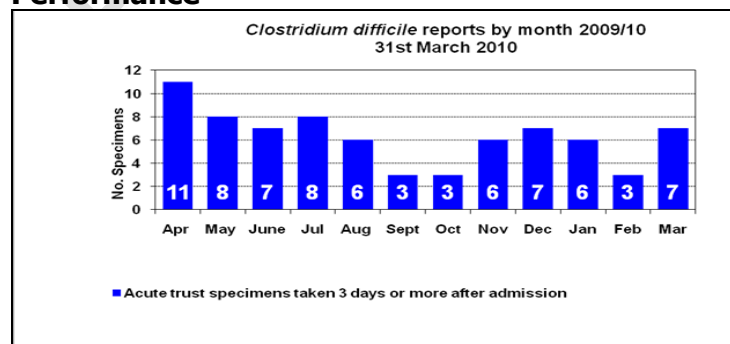
Our current performance on *Clostridium difficile* reduction is over-achievement of our reduction target for 2009 - 2010 (end of year = 75 against a ceiling of 76). We reduced the number of *Clostridium difficile* cases by 20% compared with the year before. There is significant mortality and morbidity associated with *Clostridium difficile* disease and therefore this remains a high priority for the Trust.

Aim/Goal

To further reduce our *Clostridium difficile* rate.

The trust has been set a target to reduce *Clostridium difficile* infections during 2010/11 to 56 cases. Increasing patient safety by reducing infection is a key priority and consequently we have set an internal target of no avoidable infections.

Performance



Identified Areas for Improvement

- Antibiotic stewardship
- Time to isolation for patients newly diagnosed or admitted with symptoms

New initiatives to be implemented during 2010/11

- Refined antibiotic teaching for junior doctors
- Joint root cause analysis with patients' GPs for every case of proven infection
- Review of the use of our bed management strategy for isolation facilities

3.1.1.2. To further reduce our MRSA blood stream infection cases

Description of Issue and Rationale for Prioritising

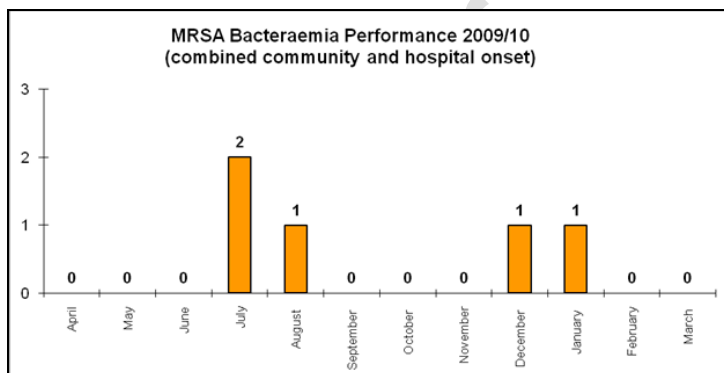
Performance on MRSA blood stream infection (bacteraemia) was 1 better than the set target with an end of year performance of 5 cases against a ceiling of 6. MRSA bacteraemia has a significant associated morbidity and mortality and is an important patient safety consideration. The target is set for the whole health economy although reported as a measure of Bedford Hospital Trust. Of the five cases reported, three specimens were taken on admission to hospital, indicating that the infection was already in place prior to the patients admission. Bedford Hospital NHS Trust has reduced hospital-onset MRSA bacteraemia by 91% in the last five years.

Aim/Goal

No avoidable MRSA bacteraemias, and a target set by our commissioners of no more than three cases during 2010 - 2011

Performance

Number of MRSA Bacteraemia cases by month for 2009/10



Identified Areas for Improvement

- Compliance with care bundles for invasive devices
- Work more collaboratively with NHS Bedfordshire to lower the risk to patients in the community

New initiatives to be implemented during 2010/11 – see part 1

- Trust-wide implantation of aseptic non-touch technique (ANTT)

3.1.1.3. To achieve a reduction in patient falls

Description of Issue and Rationale for Prioritising

Demographic changes within the local population mean that an increasing proportion of the population is elderly or infirm patients who are prone to falling.

Falls are among the most frequently occurring incidents reported through our incident reporting process. National guidance from NICE has advised on best practices to be implemented to control the risks and improve the care for this group of patients.

Aim / Goal

Reduce patient falls from bed or trolley by 10% in year.

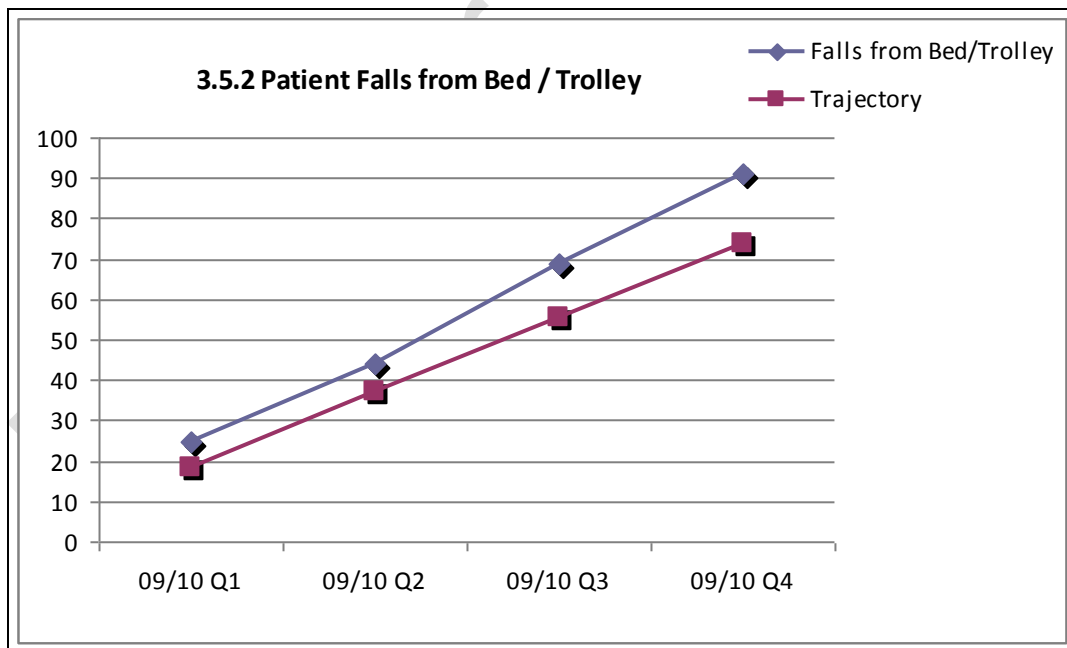
Performance

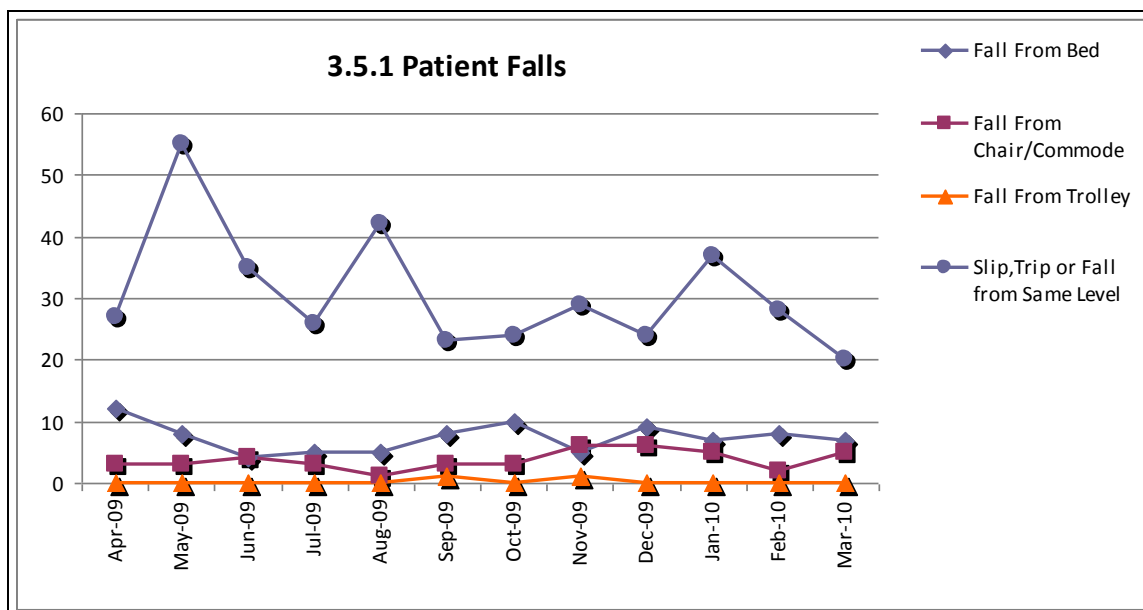
Falls prevention measures have been deployed as stated in last years report and the identified areas for improvement have been achieved and also extended further for this year with additional initiatives included.

There were a total of 88 falls from bed or trolley during the period 1/4/09 to 31/3/10. The total falls were divided into 86 from a bed and 2 from a trolley.

The agreed 10% reduction was to have no more than 74 falls during the year. This was breached by an additional 14 falls.

However, one patient was reported having fallen from the bed on three occasions in May. The highest figure from falls from beds was reported in April where one patient had fallen from the bed twice. The age range of the April falls was from 74 years, the majority being in their 80's. The time range was 60% between midnight and 6a.m. and 40% between 16.30 and 20.40p.m.





New initiatives to be implemented during 20010/11

- Implement a Guideline for patient assessment for Doctors on post admission falls
- Sloppy slipper Campaign – to make slippers available for purchase within the Trust
- Specialist Care Plan – Urinary Incontinence designed to reduce the risks associated with incontinence patients falling whilst attempting to walk to the toilet
- Extension of productive ward initiative throughout the Trust
- To extend the Falls Register, this is now being piloted by the Ambulance service. The intention is for the Falls Register to be populated by all organisations including Acute Trusts.
- Dexa scanning discussions are taking place to explore the feasibility of developing a fracture liaison service in Bedford.

*"DON'T judge the quality of care by crude falls rates or panic because there is an increase in falls on one ward over a month or two
The numbers are small and one patient with dementia and agitation can skew the data."*

The 'How to' Guide for reducing harm from falls.
Patient Safety First (Sept 2009)

3.1.1.4 To achieve a reduction in pressure ulcers

Description of Issue and Rationale for Prioritising

Pressure ulcers are avoidable and a widely used indicator of quality of care for which there is NICE best practice guidance.

Aim / Goal

To achieve a 2% reduction in pressure ulcers and zero tolerance of hospital-acquired Grade 3 and Grade 4 pressure ulcers.

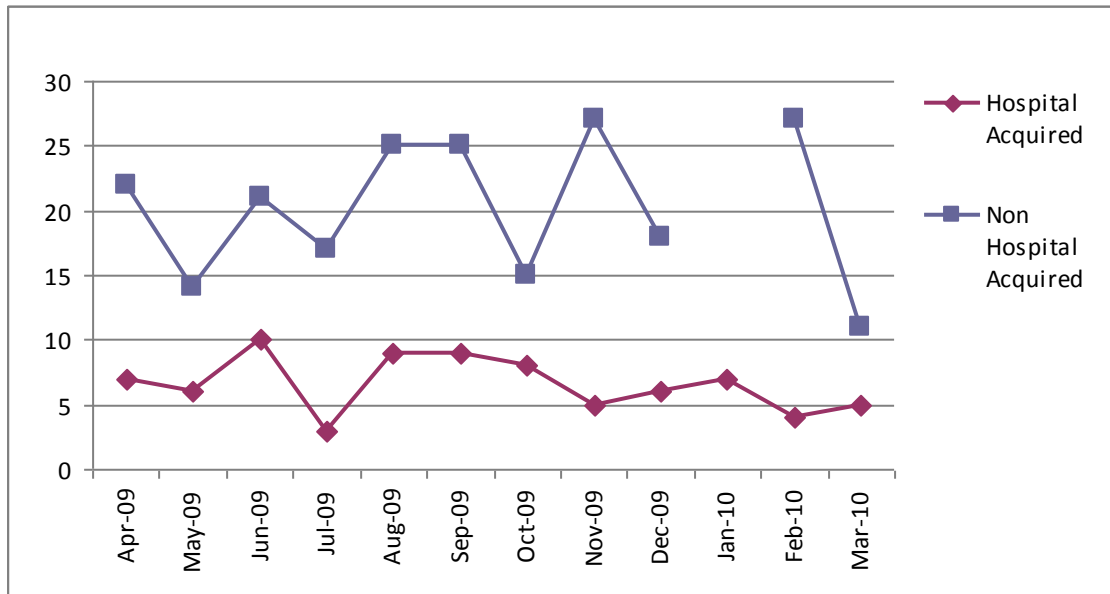
Performance

The total number of Hospital –acquired pressure ulcers reported during the period was 79 which have reduced from the 2008/09 total of 154 (but some caution is to taken in interpreting this trend and the trust board is aware of some weakness in the wards' data

collection process). The numbers of patients coming into hospital with pressure sores from the community has increased from 218 in 2008/09 to 222 + in 2009/10.

Grade 3 and 4 pressure ulcers have continued to be reported

Total Pressure Ulcers 2009/10



The vacancy in the Tissue Viability Specialist Nurse post was filled during this period which is vital to leading and coordinating the service to patients.

Attention has been given to ensuring the trust's stock of pressure-relieving surfaces is in the best possible condition. New mattresses were installed at the beginning of the year and the trust has renegotiated the contract for the dynamic bed systems.

New initiatives to be implemented in 2010/11

The trust has created a Tissue Viability Steering Group for a multidisciplinary approach to implementing the Tissue Viability Strategy which is key to achieving the zero tolerance approach to pressure ulcers. The group will be reviewing the governance and systems approaches in place.

Key aims:

- to implement a comprehensive training programme for nurses on Tissue Viability
- To provide a prompt response to the patient's needs for dynamic bed systems and additional pressure-relieving equipment within 30 minutes of the assessment.

3.1.1.5 To achieve a reduction in medication errors

Description of Issue and Rationale for Prioritising

Administration of medication is a high volume activity in a hospital environment. Ward pressures and medication system can be pressured and susceptible to errors. Prescribing training is an inherent part of junior doctor training.

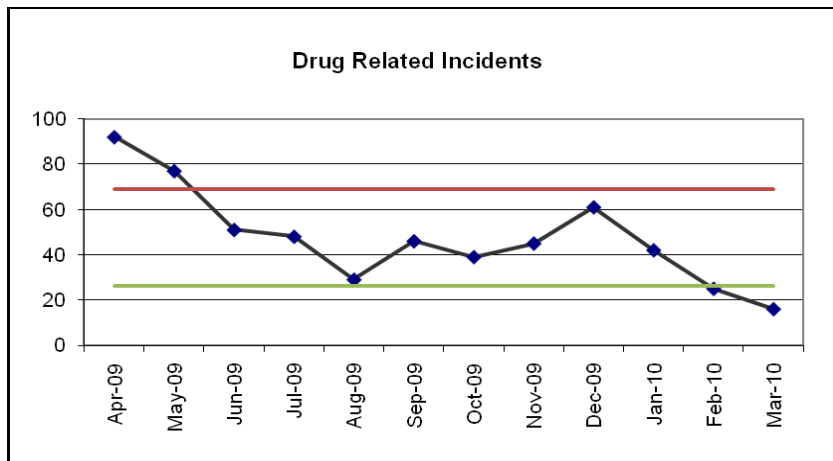
Pharmacist interventions identify potential risks at an early stage to avoid harm.

Aim / Goal

To reduce medication errors with moderate or major potential for harm.

Performance

There have been no instances of major harm due to drug errors during the period.



Performance against the areas identified for improvement

Workbenches have been installed in ward areas for the preparation of injectable medicines. This is in response to the action required to implement the National Patient Safety Alert (NPSA) 2007/20 *Safer use of injectable medicines*.

The Safer Medication Group and the Patient Safety Committee regularly review the trends in medication errors. A major category of error comes in the prescribing stage of the patient pathway in as much as on admission, the patient's regular medication needs to be accurately transferred to the inpatient notes and the regular medication continued. It is recognised that lack of information on patients' drugs on admission and inaccurate reconciliation of drugs can result in a chain of error throughout the patient's stay. Additional resources have been deployed to the pharmacy staff to check the patient's drugs on admission and ensure the prescription charts include all the patient's regular medications.

Training has continued to be delivered by the trust Chief Pharmacist to junior medical staff on prescribing and medicines management.

The graph above is extracted from the trust Datix incident reporting system. The reduction in Drug Related Incidents for Q3 and Q4 is interpreted as relating to the under reporting of Pharmacy Intervention incidents, which have not been added to the database due to the lack of staff resources to input the data. However the process described above ensures that the risk of harm from wrong or missing medication is reduced.

A focus on the management of Diabetic patients has taken place during the period with a local drive for the national "Think Glucose" campaign and with the aim of reducing the number of insulin related errors

Identified areas for improvement

- Venous Thromboembolism, risk assessment and prescribing – see Priorities for Improvement / Patient safety including revision of prescription administration chart to improve risk assessment for thromboprophylaxis.(medicine to prevent blood clots from forming)
- The trust continues to implement the requirements of the NPSA Safety Alerts relating to medicines management
- Anticoagulation therapy
- Safer antibiotic prescribing

3.1.2 Patient Experience

3.1.2.1 To achieve improvement in what patients tell us about our services and care through the national patient survey

Description of issue and rationale for prioritising

The NHS Next stage review put emphasis on trusts gaining a better understanding of the patient's experience and for resultant improvements to services. WE aim to provide a service that meets not only the patients physical needs but their emotional ones too.

Aim / Goal was

To improve the percentage of favourable responses from patients on the quality of their care in the National Patient survey by 25%

Performance

National Survey questions	2008	2009
Were you involved as much as you wanted to be in decisions about your care and treatment?	52%	42%
Did you find someone on the hospital staff to talk to about your worries and fears?	38%	35%
Were you given enough privacy when discussing your condition and treatment?	70%	66%
Did a member of hospital staff tell you about medication side effects to watch for when you went home?	35%	28%
Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	67%	64%

(Further Commentary on the trust performance will be possible on release of the CQC national benchmarked results report)

New initiatives to be implemented during 2009/10

– see section in Part 1

3.1.2.1. To establish liaison with the newly formed LINK organisation

Description of issue and rationale for prioritising

The PPI Forum has been dissolved and the new LINK organisations established. The Trust regards this group as vital to the development of the partnership with patients and for the development of understanding of the patient's experience

After the launch event members of the LINK are members of the key committees within the governance structures of the trust including the Improving the Patient Experience Committee and the Action on Patient Information Group.

Aim / Goal was

To establish liaison with the newly formed LINK organisation

Performance

LINKs members have attended the committees throughout the year and contributed to the discussion on lessons learned from the complaints that have been a main agenda item.

New initiatives to be implemented during 2010/11

- new partnerships with the Bedford LINK
- see Part 1 for the priorities around implementing the Patient Experience strategy
- develop and annual improvement plan based on delivering the trust *Improving the Patient Experience Strategy*

3.1.3 Effectiveness of Care

3.1.3.1 Stroke care

Aim / Goal

To develop an evidence-based stroke / TIA service from acute care to community rehabilitation that meets expected standards for the TIA outpatient services and provides timely thrombolysis at acute onset.

Performance

The trust performance in the care of stroke patients has been closely monitored through the CQUINs process using the following indicators

Indicator	Achieved 2009/10
Brain imaging within 24hrs of a stroke being diagnosed or suspected by a clinician	216 (77%)
Brain imaging for appropriate patients within 1hr of a stroke being diagnosed or suspected	12/210 (6%)
Thrombolysis in appropriate patients presenting with stroke and who are eligible	6/56 (11%)
Percentage of patients who were treated for more than half their stay in the stroke unit	79%

Clinical Outcome measures

Stroke Stroke mortality (HRG A22 & A23)	14.35%	11.82%	17.37%	<i>CHKS data</i>
No of deaths within 30 days of admission amongst patients with a primary diagnosis of stroke	41 (14%)			<i>Trust Stroke unit data</i>
Readmissions	9.8%	8.4%	5.8%	<i>Chks data</i>

Progress with Identified Areas for Improvement

- A dedicated TIA clinic to review patients at high risk of developing a stroke has been established.
- Provision of thrombolysis treatment to improve patient outcomes has commenced – see performance indicators.

New initiatives to be implemented during 2009/10

Stroke Physician appointed April 2009

Stroke Service Plan to be implemented in 2009/10

3.1.3.2 Introduction of a new procedure: Endovascular Aneurysm Repair (EVAR)

Description of Issue and Rationale for Prioritising

The vascular service is one of the key service developments identified in the Foundation Trust application. The introduction of endovascular aneurysm repair (EVAR) is an example of how new procedures are introduced to the Trust to support this initiative.

Aim / Goal

To provide modern keyhole interventions with improved outcomes for appropriate patients.

Performance

Nineteen case were undertaken. Each case was selected according to current PCT criteria for funding.

Mortality 0%

New initiatives to be implemented during 2010/11

This procedure will continue to be offered as part of the trust vascular Services.

This topic will be “retired” as a focus for reporting in future Quality Accounts.

3.2 Stakeholder Involvement

The draft Quality Account has been produced through a distillation of the issues reported via the trust assurance systems: The divisional quality performance issues are reported to the Quality Performance Committee; the areas for improvement in safety to the Patient Safety Committee and the views expressed by the patients' representatives, complaints, patient satisfaction feedback and other interested cross-trust groups, to the Improving Patient Experience Committee.

The Bedfordshire PCT has also indicated their priorities for improvement in quality during the discussions to set the contract for 2010/11.

This draft for consultation will be circulated to all clinical teams within the trust during the consultation period including the Joint Staff Management Consultative Committee.

3.3 Statements from third parties

This Quality Account has been forwarded to the following parties for consultation:

Bedfordshire PCT

Bedford Borough Overview and Scrutiny Committee

Bedford LINK

4.0 How to provide Feedback on this Quality Account

We welcome comments and feedback on these Quality accounts, as well as suggestions on content for

If you would like to provide feedback or comments, please do so via

Email: Communications@bedfordhospital.nhs.uk

Or in writing to

Bedford Hospital NHS Trust
Kempston Road
BEDFORD
MK42 9DJ

01234 355122

Appendix 1: Bedford Hospital NHS Trust - Services provided

	Service Description	Outpatients	Day cases	Elective Inpatients	Emergency Admission
180	Accident and Emergency	√	√	√	√
320	Cardiology	√	√	√	√
192	Critical Care Medicine (ITU)			√	√
330	Dermatology	√	√	√	√
	Dexa Scanning	√			
330	Tunable Dye Laser Treatment	√	√	√	
307	Diabetic Medicine	√		√	√
430	Elderly Care	√	√	√	√
302	Endocrinology	√	√	√	√
120	ENT	√	√	√	√
301	Gastroenterology	√	√	√	√
300	General Medicine	√	√	√	√
100	General Surgery	√	√	√	√
103	Breast Surgery	√	√	√	√
106	Upper GI	√	√	√	√
104	Lower GI	√	√	√	√
107	Vascular	√	√	√	√
502	Gynaecology	√	√	√	√
309	Haemophilia	√			
560	Midwifery	√	√	√	
370	Medical Oncology	√	√	√	√
361	Nephrology	√	*	*	*
400	Neurology	√	*	*	*
422	Neonatal	√	√	√	√
501	Obstetrics	√	√	√	√
901	Occupational Medicine	√			
130	Ophthalmology	√	√	*	*
140	Oral Maxillo Facial (144)	√	√	*	*
143	Orthodontics	√	√	√	√
420	Paediatrics	√	√	√	√
190	Pain Management	√	√	√	√
160	Plastic Surgery	√	√	√	√
997	Podiatry (Chiropody)	√			
	Radiology	√			√
410	Rheumatology	√	√	√	√
340	Thoracic Medicine	√			
360	Genito-Urinary Medicine/Sexual Health	√	√	√	√
110	Trauma & Orthopaedics	√	√	√	√
101	Urology	√	√	√	√
820	General Pathology	√	√	√	√

821	Blood Transfusion		√		
822	Chemical Pathology				
823	Haematology	√			
824	Histopathology				
830	Immunopathology				
831	Microbiology				
810	Radiology (incs MRI/CT Ultrasound)	√			
	Sub-specialities				
	Audiology	√			
	Dietetics	√			
	Occupational Therapy	√			
	Orthotics	√			
	Orthoptics (130)	√			
	Respiratory	√			
	Retinopathy Screening	√			
	Service Departments				
	Pharmacy	√			
	Physiotherapy	√			
	Speech Therapy	√			
	Theatres				
	Acute Admissions Unit	√	√	√	√

* Indicates a service provided by another NHS organisation

D = Distinctive services: a specific type of activity/procedure provided within the main or treatment specialty.

Draft for Consultation