Bedford Hospital NHS
NHS Trust

Bedford Hospital NHS Trust

Quality Account 2013/14

Consultation Draft

every patient matters

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Part 1: Introduction to our 2013/14 Quality Account

Statement on Quality from the Chief Executive

Safe, effective care and a good patient experience, the cornerstones of quality in the NHS, is at the centre of everything we do at Bedford Hospital.

I am very proud of the quality of care we provide at Bedford Hospital to the hundreds of thousands of patients who use our services throughout the year. We have achieved a great deal in 2013/14; notably with our continued reduction in infection rates; initiatives to improve dementia care; more collaborative working to support patients fit for discharge; new equipment; refurbished wards; and, significantly fewer falls resulting in patient harm.

We have also worked successfully to overcome a number of challenges, including acting on the findings of a Care Quality Commission inspection in July 2013. This report highlighted good practice, but also inconsistency in quality standards across our wards and departments, meaning patients were not always receiving the high standard of care that they should.

As a result we have made fundamental changes, both to the way in which care is delivered, and in how we monitor and assess the quality of the care and services we provide to patients. Meeting and overcoming these challenges has undoubtedly made us a better, stronger, more transparent organisation.

Ensuring we provide consistently good care is now truly at the heart of our governance and decision-making processes as part of our commitment to getting it right for every patient, every time.

We have embraced a new regime of quality assessment and inspection, inviting our partners, including Bedfordshire Clinical Commissioning Group, Local Authorities, Healthwatch, local councillors and Patient Council members to form joint quality review teams to assess our care provision. This external scrutiny helps us to make sure our facilities and staff are meeting patients' needs, and particularly the needs of the most vulnerable in our care.

Our non-executive board directors have also begun a scheme where they spend three hours every three months in a ward or department, learning about the work taking place and assessing the quality of care and services being provided from a patient perspective. This is invaluable in connecting the board of directors to the patient bedside, and putting patient experience and safety at the heart of board discussion. We also now hold a monthly public board meeting so our patients and local residents can hear about the work we are doing to improve care and services, and how we are listening and learning when things don't go as well as we would want.

The significant progress and achievements we have made has been recognised by the CQC, who re-inspected the hospital in November 2013 and praised the transformation in the standards of care quality across our wards.

We have adopted the recommendations in Sir Robert Francis QC's report following the Mid Staffordshire University Hospitals NHS Foundation Trust public inquiry, and the Government's response: *'Hard truths, the journey to putting patients first'*; including increasing the number of nurses working on our wards and committing to publishing our nurse-to-patient ratios every day. We welcomed more than 60 nurses from Spain to our team towards the end of 2013, along with local and national recruitment campaigns, and we continue to recruit our local student nurses upon graduation.

We have a robust quality governance process from board to bedside, with a clear reporting and escalation structure from wards and departments to clinical business units; through to our executive quality and risk boards; non-executive quality and clinical risk committee and the trust board. This enables the effective ongoing management monitoring and independent scrutiny of the quality of care we provide, and ensures that issues are identified, acted upon and escalated.

We have refreshed our organisational objectives for 2014, reflecting the CQC domains of well led, safe, caring, effective and responsive. Our objectives are all based on our commitment to continuous quality improvement and our commitment to provide excellent care to the people of Bedfordshire.

Next year will bring with it more opportunities to make the care we provide better and more efficient, to meet the needs of local people as well as national quality, performance and financial targets.

I look forward to continuing to work alongside patients, carers, stakeholders and staff to listen, learn and grow as a hospital providing great care for the people of Bedfordshire.

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

Stephen Conroy

Chief Executive

Part 2: Review of quality performance in 2013/14

In our 2012/13 Quality Account we identified three quality improvement priorities for 2013/14:

1. In relation to patient safety our priority was to reduce infections
2. In relation to patient experience our priority was to achieve improvements in the areas of most concern to patients, such as reducing noise at night on our wards
3. In relation to clinical effectiveness our priority was to prevent avoidable deaths

Our progress in addressing these improvement priorities is presented in pages 7 to 17.

1. Patient safety priority 2013/14: Reduce infections

In our 2012/13 Quality Account we identified reducing infections as our patient safety improvement for this year. Our overarching aim was for no patients to develop preventable infections whilst in our care.

We set three targets to measure our progress in achieving this aim:

1.1 Reduce MRSA Bacteraemia to 0 cases

1.2 Reduce *Clostridium difficile* to less than 15 cases

1.3 Isolate 80 percent of patients with suspected infectious diarrhoea within two hours

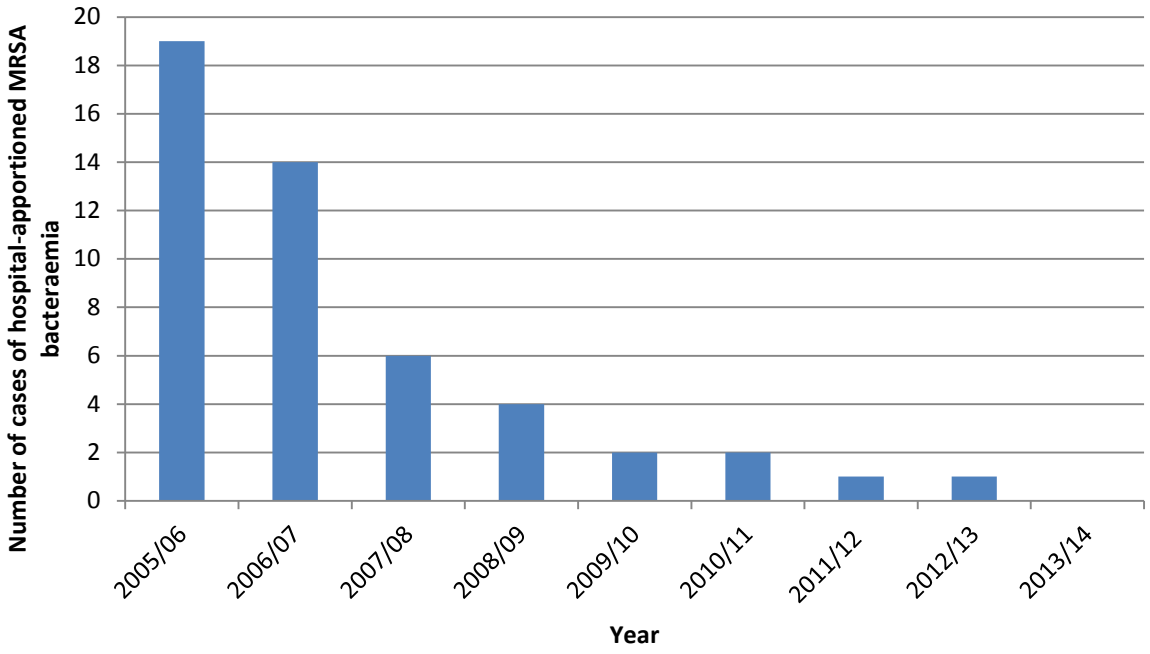
1.1 Reduce MRSA Bacteraemia to zero cases

MRSA (*methicillin resistant Staphylococcus aureus*) is a well-known healthcare associated infection. It is estimated that three percent of the general population carry MRSA harmlessly on their skin. The risk for hospital patients may be increased due to wounds, or invasive treatments which make them more vulnerable. Serious MRSA may result in blood stream infection (bacteraemia).

Our target for 2013/14 was for zero cases of MRSA bloodstream infections in our hospital. We have achieved this target.

Since 2005/06, we have seen a significant decline in the number of hospital-apportioned MRSA bacteraemia cases each year, with 2013/14 signifying the first year we had no cases at all (Figure 1).

Figure 1: Bedford Hospital NHS Trust hospital-apportioned MRSA bacteraemia cases since 2005/06



During 2013/14 the Trust has undertaken the following actions to improve our rate of MRSA bacteraemia infections:

- Medical devices that penetrate the body either through a body orifice or through the body surface (invasive devices) are monitored daily. Compliance audits are undertaken on a monthly basis and we have been reporting our achievements of this on via the infection prevention and control dashboard.
- Continued staff competencies for Aseptic Non Touch Technique (ANTT); a number of staff are trained and are now competent with this practice.
- Continued routine MRSA screening for all patients who are admitted as an emergency or as a planned admission is in place.
- Treating patients according to guidelines who have a known history of MRSA or who are identified carrying MRSA following admission with skin antiseptic wash and nasal treatment.
- New methodology for monthly monitoring of hand hygiene auditing implemented and reported via the infection prevention and control dashboard.

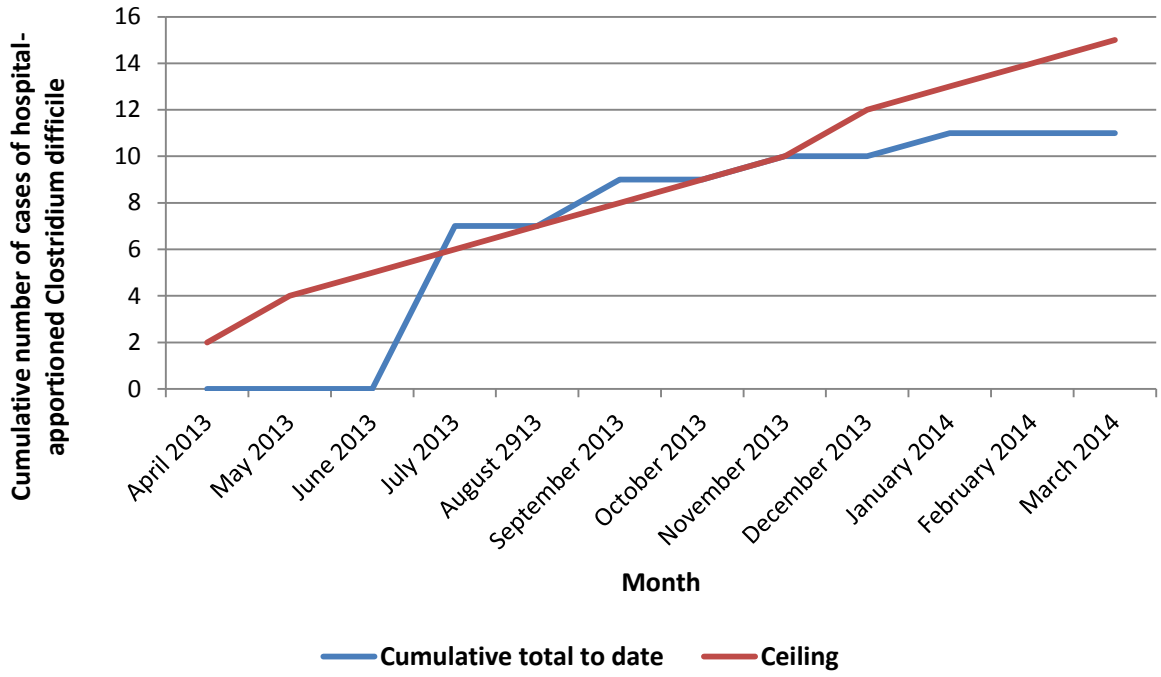
1.2 Reduce *Clostridium difficile* to less than 15 cases

Clostridium difficile is a common cause of hospital acquired diarrhoea. It is a bacterium that is present in the bowel of three to five percent of healthy adults, and up to 30 percent of elderly patients. When certain antibiotics disturb the balance of bacteria of the bowel, *Clostridium difficile* can multiply rapidly and produce toxins which cause diarrhoea and illness.

Our target for 2013/14 was to reduce the number of *Clostridium difficile* cases to less than 15.

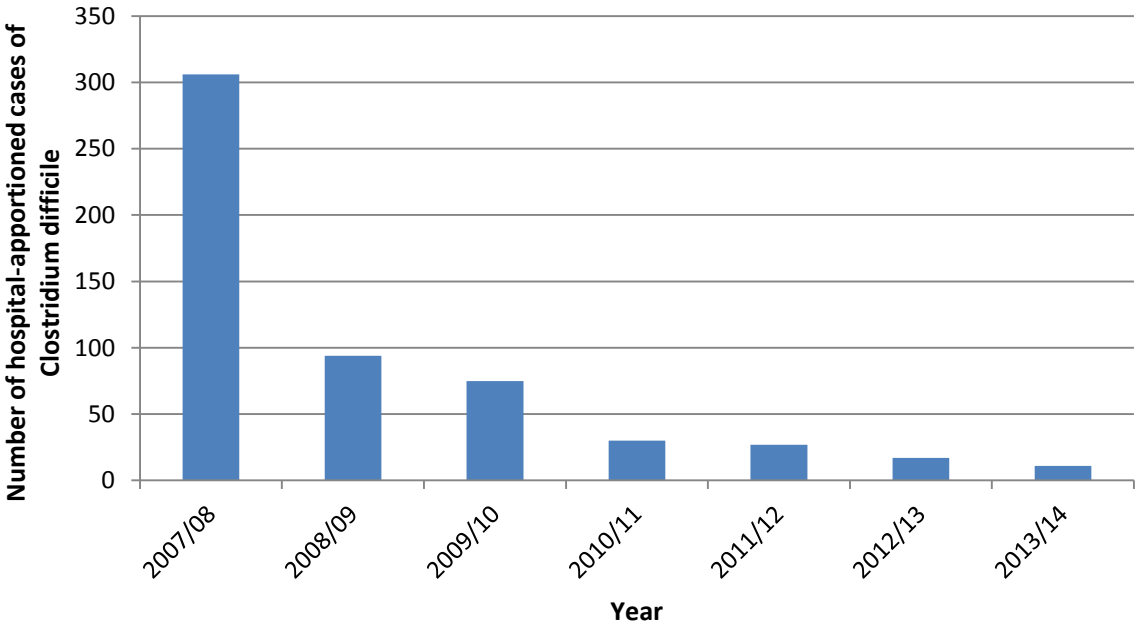
We have achieved this target. There have been a total of 11 cases of confirmed *Clostridium difficile*, which resulted in the Trust achieving four cases below our trajectory ceiling of 15 cases during the year. Figure 2 shows our monthly performance during 2013/14.

Figure 2: Bedford Hospital NHS Trust hospital-apportioned cases of *Clostridium difficile* in 2013/14



Since 2007/08, we have seen a significant decline in the number of hospital-apportioned *Clostridium difficile* cases each year (Figure 3).

Figure 3: Bedford Hospital NHS Trust hospital-apportioned cases of *Clostridium difficile* since 2007/08



During 2013/14 the Trust has undertaken the following actions to improve our rate of *Clostridium difficile* infections:

- Diarrhoea hotline implemented for all staff to report patients with symptoms of diarrhoea promptly to the infection prevention and control team.
- Multi-disciplinary *Clostridium difficile* root cause analysis[1] continues to be undertaken for each hospital case identified.
- Our antibiotic policy was reviewed to restrict the use of certain broad spectrum antibiotics which could contribute to *Clostridium difficile* infections.

1.3 Isolate 80 percent of patients with suspected infectious diarrhoea within two hours

Our target for 2013/14 was to isolate 80 percent of patients with suspected infectious diarrhoea within two hours. We have achieved compliance of over 80 percent. A month-on-month improvement has been noted since the implementation of the time to isolate data in July 2013.

[1] Root cause analysis is a structured investigation that aims to identify the true cause of a problem, and the actions necessary to eliminate it.

In January and February 2014 we experienced an outbreak of viral gastro-enteritis and our ability to meet the target 2-hour isolation was challenged, as shown in Figure 4.

Figure 4: Bedford Hospital NHS Trust isolation of patients with suspected infectious diarrhoea within two hours in 2013/14

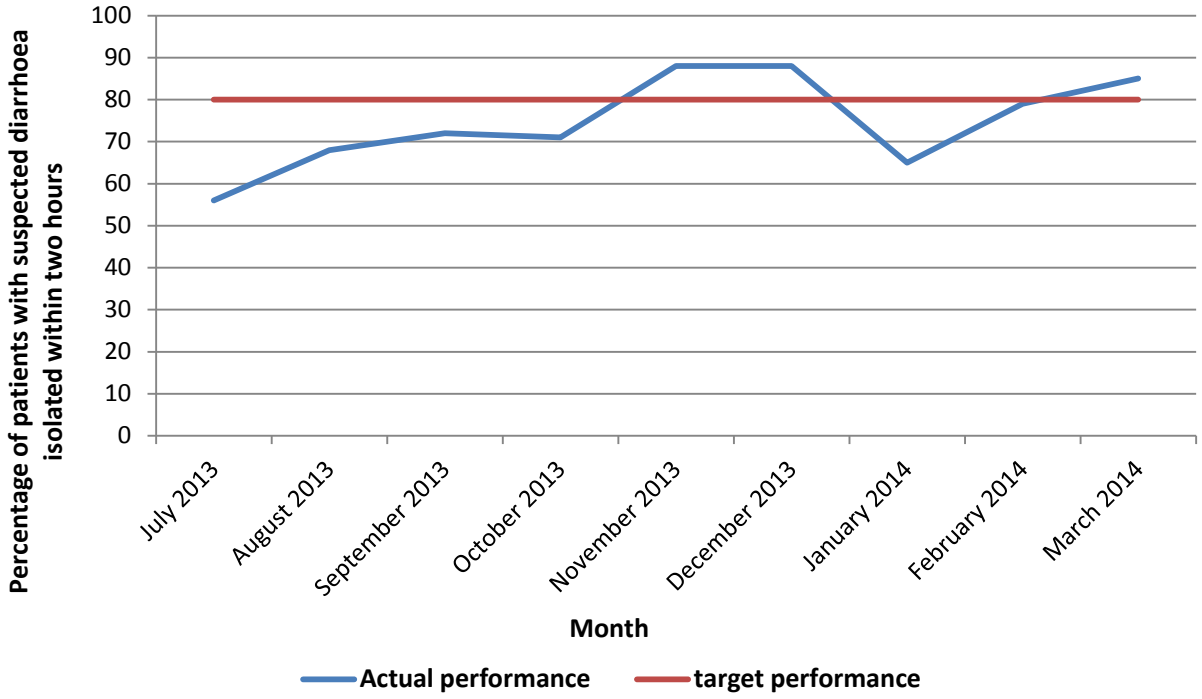


Figure 4 presents data for the period of July 2013 to March 2014. Data from March to June 2013 has not been included as the parameters of the measure were changed in July 2013. Prior to this, we collected data relating to all patients with diarrhoea. However, in July 2013, following advice from our auditors, we moved to measuring only those patients with suspected infectious.

During 2013/14 the Trust has undertaken the following actions to improve isolation of patients with suspected infectious diarrhoea within two hours:

- Data collection methodology implemented to capture information on the time a patient with suspected infectious diarrhoea has been isolated, this includes the escalation procedure if isolation not achieved within 2 hours.
- Successful introduction of a diarrhoea hotline to enable staff to report patients with symptoms of diarrhoea promptly to the infection prevention and control team.
- Introduction of a new standard operating procedure for the management of single rooms implemented.
- Training provided to all bed managers and on using the new standard operating procedure.

- Progress is reported monthly via the monthly HIPCC and monthly quality scorecard which is reported to the Quality and Risk Committee.

2. Patient experience priority 2013/14: Achieve improvements in areas of most concern to patients

Our overall aim in relation to patient experience in 2013/14 was to increase the number of patients who say they would be likely to recommend Bedford Hospital to a friend or family member based on their own experience.

We set three targets to measure our progress in achieving this aim:

2.1 Achieve a 2.5 point increase in positive responses to the following in-patient survey questions relating to personal needs:

- Did a member of staff tell you about medication side effects to watch out for when you went home?
- Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?

2.2 Increase Friends and Family Test score by 10 points to 70

2.3 Improve the areas of most concern to patients:

- Noise at night
- Discharge process

Our progress in meeting these targets is set out in Table 1**.**

Table 1: Progress in achieving our patient experience priority targets for 2013/14

Target	Performance in 2012/13	Performance in 2013/14	Target achieved?	Commentary
2.5 point increase in positive responses to "Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?"	23 percent	22 percent	No	Results from Picker Institute National Survey July 2013 The decrease from 23 percent to 22 percent represents a decline in patients reporting that they were not informed to medication side effects
Increase Friends and Family Test score by 10 points to 70	60	59	No	In 2013/14 we extended the Friends and Family Test to include A&E attendances in addition to inpatients. This increased the survey size from 500 to approximately 3500. The score of 59 is the result from the inpatient element of the survey. When the A&E element is included the 2013/14 FFT score reduces to 50.
Improve the areas of most concern to patients: noise at night from staff	24 percent	19 percent	Yes	Results from Picker Institute National Survey July 2013 The decrease from 24 percent to 19 percent represents a decline in patients reporting that they were not bothered by noise from staff at night
Improve the areas of most concern to patients: noise at night from other patients	43 percent	45 percent	No	Results from Picker Institute National Survey July 2013 The increase from 43 percent to 45 percent represents an increase in patients reporting that they were bothered by noise from other patients at night
Improve the areas of most concern to patients: discharge process	40.7 percent	39.5 percent	Yes	Results from Picker Institute National Survey July 2013 – performance figure is based on the average of 19 questions

Target	Performance in 2012/13	Performance in 2013/14	Target achieved?	Commentary
				relating to the discharge process The decrease from 40.7 percent to 39.5 percent represents a decline in patients reporting negatively on their experience of leaving hospital

Note: all 2013/14 figures are based on data published by the Picker Institute in July 2013 (quarter two of the financial year)

During 2013/14 the Trust has undertaken the following actions to improve our performance in areas of concern to patients:

- A Patient Led Assessment of Care Environments (PLACE) took place in 2013 which was led by Patient Council Members. This is an annual audit of care environments from a patient's perspective. In 2013, the assessment scores were overwhelmingly positive:
    - Cleanliness: 98 percent
    - Food: 92 percent
    - Privacy, dignity and wellbeing: 91 percent
    - Condition, appearance and maintenance: 94 percent
- Members of the Patient Council and local Healthwatch branches have taken part in the majority of our Quality Review Scheme ward assessments, giving us invaluable feedback from a patient's/carer's perspective
- We introduced a Patient Carer Representative on the Trust-wide Dementia Steering Group – the group is chaired by the Deputy Director of Nursing and oversees the care we provide to patients with dementia and pursues improvements on behalf of these patients
- In April 2013, the Environmental Cleanliness Group has recruited a lay member – the group meets on a fortnightly basis and monitors action plans implemented following environmental audits. The group also responses to environmental on an ad hoc basis.
- Noise at Night Bundle was successfully introduced across the Trust with patients reporting a reduction in noise staff and environmental noise at night after carrying out the following:
    - Environmental checks on sources of noise such as bin lids, phones and doors
    - Staff checks to ensure that, at night, they wear appropriate shoes, speak in hushed tones
    - Checks on visitors after 10pm to ensure they do not create excess noise
- The Trust had not fully considered the impact of noise from other patients last year – going forward this will be addressed
- A matron has led improvements in the discharge process including integrating the hospital and community discharge teams to work as one and to increase the whole time equivalents in that team
- The new Discharge Lounge was launched and has been running successfully

3. Clinical effectiveness priority 2013/14: Preventing avoidable deaths

Our aim for 2013/14 was to achieve a mortality rate of less than 100, with the Trust's performance defined as 'lower than expected' by the Department of Health.

We set three targets to measure our progress in achieving this aim:

3.1 Reduce hospital-wide mortality

3.2 Reduce mortality rates per speciality

3.3 Regularly review specialty-level quality indicators

Our progress in achieving these aims is set out in pages 17 to 22.

3.1 Reducing hospital-wide mortality

During the 2012/13 financial year, the NHS Choices website began to publish standardised hospital mortality indices (SHMI) for all acute hospital trusts. The SHMI figure describes the average number of patient deaths during an inpatient spell or within 30 days of discharge against a national average of 100. The figure is calculated taking various factors into account and is reported six months in arrears for a rolling 12 months. During 2013/14, our NHS Choices SHMI increased from 103 (reported in the first quarter) to 110 (reported in the last quarter). Despite this increase, our NHS Choices SMHI has remained within the 'expected' range, which has an upper limit of around 113. The latest published SHMI for the Trust has decreased to 108 (published in April 2014).

In order to provide continued assurance of our mortality rates the following actions have taken place over the last year.

3.2 Reducing specialty-level mortality rates

In addition to the NHS Choices SHMI, the Trust uses other sources of data to monitor and assess our mortality rates. We obtain further mortality information from the data analysis firm CHKS. This allows us to view the SHMI for inpatient deaths (excluding deaths occurring within 30 days of discharge, which are included in the NHS Choices SHMI) at the Trust level and within specialties. CHKS also provides a Risk Adjusted Mortality (RAM) rate. The RAM is based on all hospital deaths

and is adjusted to take into account any additional diseases or diagnoses that a patient may have had that were not the primary cause of death. This is a particularly useful measure as it provides additional context to our mortality rates. For example, our Trust-level SHMI for 2013 is 73, which is higher than our peers[2] (70) (see Table 2). However, our RAM (82) is significantly lower than our peers (91). This suggests that our patients were 'sicker' (i.e. multiple diseases/diagnoses at the time of death) than those of our peer hospitals.

Table 2 compares the in hospital SHMI and Risk Adjusted Mortality data for the calendar years 2012 and 2013. This table also provides the average performance of our peer group.

Table 2: Bedford Hospital NHS Trust mortality rates

	Inpatient SHMI (excluding deaths occurring within 30 days of discharge)	Peer Inpatient SHMI (excluding deaths occurring within 30 days of discharge)	Risk Adjusted Mortality	Peer Risk Adjusted Mortality
Bedford Hospital NHS Trust				
2012	78	73	91	100
2013	73	70	82	91
Medicine				
2012	80	75	92	101
2013	76	72	83	92
Surgery				
2012	73	65	89	95
2013	61	64	79	89
Women and Children				
2012	22	45	23	42
2013	38	44	47	41

In 2013 there were improvements in mortality rate measures at a Trust-level, and within medicine and surgery (highlighted in green). Mortality rates within the Women and Children specialty have increased compared to 2012. This has been attributed to an increase in the total number of neonatal

[2] CHKS identifies fifteen similar acute trusts to use as a peer group. This peer group will have a similar profile to Bedford Hospital NHS Trust.

deaths compared to 2012 (5 deaths in 2013 compared with 2 in 2012). Three of the neonatal deaths in 2013 occurred following live births before 22 weeks' gestation.

3.3 Reviewing mortality rates within specialities and Clinical Business Units

Towards the end of 2013/14, we developed a Mortality Review Policy, which ensures that all deaths are reviewed by an independent consultant using the Trust's review proforma and following the grading system developed by the National Confidential Enquiry into Patient Outcomes and Death (NCEPOD) (see Table 3).

Table 3: NCEPOD Classification of Care

NCEPOD Classification of Care		
A	Good Practice	A standard that you accept for yourself, your trainees and your institution
B	Room for Improvement	Aspects of **clinical** care that could have been better
C	Room for Improvement	Aspects of **organisational** care that could have been better
D	Room for Improvement	Aspects of both **clinical** and **organisational** care that could have been better
E	Less than Satisfactory	**Several** aspects of **clinical** and/or **organisational** care that were well below satisfactory

All deaths categorised as B to E will require discussion at CBU Mortality meetings/ Quality Group meetings. All deaths categorised as E will be escalated to the newly formed Mortality Review Group and investigated with a Root Cause Analysis[3]. All deaths in Women and Children's services are automatically subject to a full root cause investigations.

Associate Medical Directors and CBU Mortality leads will report directly to the Mortality Committee. Compliance with mortality reviews will form part of the CBU Quality Scorecard which is reported to our Quality Board on a monthly basis.

[3] Root Cause Analysis is a structured investigation that aims to identify the true cause of a problem, and the actions necessary to eliminate it.

3.4 Introduction of the Mortality Review Group

The terms of reference for the Mortality Review Group are set out in our Mortality Review Policy. The Mortality Review Group commenced in April 2013.

The Mortality Review Group will receive reports from each CBU about the results of their mortality reviews and will also consider the following:

Action	Commentary
Crude mortality, SHMI and Hospital Standardised Mortality Ratios (HSMR)	These measures will be routinely monitored both at Trust and specialty level. This information will be presented to the Board as part of the regular Mortality report
Proactive review of mortality outliers	Mortality outliers identified from internal surveillance and review of national/ CHKS data will generate a specialty level case-note review with involvement form the coding team. Any SHMI diagnostic group with has a mortality rate with a percentage difference greater that 20% from the expected mortality rate for four consecutive quarters will also undergo a case review. Results following this type of review will be presented to the Mortality Review Group.
Reactive review of externally generated mortality outlier alerts	A review will be undertaken by an appropriate clinician to comply with the timeframe identified by the CQC. The process is supported by the Information services team and the results will be reported to the Mortality Review Group.

3.5 Embedding the Mortality Assurance Framework

To ensure our mortality review process is fully embedded across the Trust we have defined a clear structure of reporting and accountability (see Figure 5). Following a patient's death a coding review will be carried out by the patient's consultant. Once this is complete, an independent consultant (e.g. a consultant working for the Trust who was not directly involved in the patient's care) will review each death using the Trust-wide mortality pro forma. This review is reported to each CBU Quality Group/ Mortality meeting. Associate Medical Directors and/or CBU Mortality Leads are responsible for ensuring that the Trust's Mortality Review Group, chaired by the Medical Director, formally reviews the results of mortality reviews.

The Quality and Risk Committee is the main assurance committee for our Trust Board, receiving reports from the Mortality Review Group via the Medical Director regarding process, outcomes of reviews and proposed actions. As part of routine business the Quality and Risk Committee will raise any concerns about the assurance it receives to the Audit Committee. The Trust Board will review monthly Mortality Reports to ensure transparency and leadership at Trust Board level.

Figure 5: Bedford Hospital NHS Trust Mortality Review Process and Reporting Arrangements

Our quality improvement priorities for 2014/15

In early 2014, the Trust revised is strategic objectives to reflect five domains of the new inspection model used by the Care Quality Commission. We used the underlying operation objectives and their key performance indicators to develop a list 14 of possible quality improvement priorities to be addressed in 2014/15.

We circulated the list of options to our stakeholders and asked them to identify three priorities, each representing one of the three aspects of care quality: patient safety; patient experience; and, clinical effectiveness. A total of 223 stakeholders completed the survey.

Our stakeholders included:

- All staff employed by the Trust
- Our patient council members
- Bedfordshire Clinical Commissioning Group
- Bedford Borough Council
- Central Bedfordshire Council
- Healthwatch Bedford Borough
- Healthwatch Central Bedfordshire

The quality improvement priorities for 2014/15 identified by our stakeholders are:

1. Patient safety: Improve care for patients whose condition is deteriorating
2. Patient experience: Improve our performance, as measured by patient survey results
3. Clinical effectiveness: Reduce readmissions

Our targets, areas for improvement and how we will monitor our progress in addressing these priorities are presented in pages 24 to 29.

1. Patient safety priority 2014/15: Improve care for patients whose condition is deteriorating

Improving how we respond to patients whose condition is deteriorating has been identified as an objective for the Trust in 2014/15. In 2009 we introduced the Critical Care Outreach Team[4] to improve how we care for our patients whose condition is deteriorating, and in 2011 this service began providing 24-hour support across the Trust.

Aim

Our aim for 2014/15 is to further improve the care we provide to patients whose condition is deteriorating

Targets for 2014/15

In order to achieve this aim, we have set the following target:

- Reduce the number of avoidable cardiac arrests

Areas of Improvement that have been introduced in 2013/14

We are continually striving to improve our performance. Over the course of the last year we have undertaken the following to improve the care we provide to patients whose condition is deteriorating:

- We carried out a thematic review of all serious incidents relating to failure to rescue deteriorating patients between 2011 and 2013 to identify themes and areas in need of additional support.
- We approved the use of Treatment Escalation Plans (TEP). There are many treatments available for patients whose condition may deteriorate. Some of treatments may be suitable and helpful whilst others may not. A TEP allows clinicians to record individualised treatment

[4] The Critical Care Outreach Team consists of a critical consultant and our senior critical care nurses. The team review patients who have been assessed on wards and are showing signs of deteriorating. The Outreach Team provides support to wards and assists in the management of these patients. The Outreach Team also provides follow-up support to patients who have required a stay in the Critical Care Complex and have been moved, following an improvement in their condition, to another ward.

plans, focusing on which treatments may or may not be most helpful for a patient. A variety of treatments can be considered, such as antibiotics, artificial feeding or ventilation a patient's lungs.

- Our mandatory basic life support training was altered to cardiac arrest prevention and now includes recognition of deteriorating patient and fluid management.
- We made changes to our cardiac arrest audit process to incorporate an examination of the management of a patient's care in the 48 hours prior to a cardiac arrest.
- We undertook a pilot programme of "Ward of Week". This programme, led by the Critical Care Outreach Team and the Cardiac Arrest Prevention Team, involved the teams working intensively with a ward for one week to increase knowledge and understanding of how to identify patients whose condition is deteriorating and when to refer these patients to the Critical Care Outreach Team.

Areas of Improvement planned for 2014/15

In order to further improve the care we provide to patients whose condition is deteriorating we will undertake the following improvements over the coming year:

- We will roll-out the use of Treatment Escalation Plans across the hospital
- Acute Life Threatening Events Recognition and Treatment (ALERT)[5] training will be mandatory for all clinical staff
- Bedside Emergency Assessment Course for Healthcare Assistants (BEACH)[6] will be mandatory for all clinical support workers
- We will increase availability of Immediate Life Support training for all clinical staff
- We will develop a new observation chart with a 'traffic light' system to improve our system of escalating patients at risk of deteriorating to the Critical Care Outreach Team
- We will continue our "Ward of Week" programme

[5] ALERT™ is a multi-professional course to train staff in recognising patient deterioration and act appropriately in treating the acutely unwell. In practice, ALERT uses a structured and prioritised system of patient assessment and management to enable a pre-emptive approach to critical illness. It instructs staff in the recognition of impending clinical deterioration, the management of disordered physiology and other aspects of the delivery of acute care.

[6] BEACH is designed to equip Health Care Assistants and Clinical Support Workers with the skills and techniques required to recognise and escalate a deteriorating patient.

How we will measure and monitor our performance

In order to monitor our progress in achieving our patient safety priority we will:

- Measure the number of cardiac arrests that our patients experience
- Carry out frequent audits of the escalation process
- Continue our involvement with National Cardiac Arrest Audit to enable benchmarking of our performance against other similar trusts.

2. Patient experience priority 2014/15: Treat our patients with dignity and respect and improve the way in which we communicate with our patients

To develop our strategic objectives in 2014/15 in relation to patient experience we examined the results of the 2013 Picker Institute Inpatient Survey. This enabled us to identify the areas of our practice where patients are reporting lower satisfaction levels compared with the national average. These specific areas have been integrated into our strategic objectives and will also be addressed through our Quality Account as a priority for 2014/15.

Aim

Our aim for 2014/15 is to improve the reported patient experience scores in relation to:

- Ensuring our patients have privacy and are treated with dignity and respect
- Making sure our patient feel involved and fully understand their care and treatment
- Improving the information we give patients undergoing surgical procedures

Targets for 2014/15

Achieve a 2 point increase in the Picker Institute Inpatient Survey scores for questions relating to:

- Patients feel they have enough privacy and dignity when discussing their conditions and treatment
- Patients feel they receive enough emotional support from our staff
- Staff respond to call bells within five minutes
- Patients feel more involved in decisions
- Patients have more time to discuss operations/procedures with consultant
- Patients feel their questions have been fully answered
- Patients are told how to expect to feel after an operation/procedure
- Patients are told what would be done during an operations/procedure

Areas of improvement that have been introduced in 2013/14

In the 2013 Picker Institute Survey noticeable improvements were seen in several areas compared to 2012. Improvements that contributed to the improvement in scores are listed below:

- Our Accident and Emergency (A&E) department introduced a booklet for patients outlining what would happen when in the department

- We undertook a campaign for all doctors and nurses within A&E to increase awareness of issues that may affect a patient's sense of dignity
- All curtains used within the hospital now have 'dignity clips' that allow staff to secure gaps in curtains during treatment and/or care
- A Royal College of Nursing video on dignity is now part of the mandatory annual clinical training for all staff
- All wards have information about the ward, including the general routine (e.g. time of meals) and the ward leaders, at entrances
- At our daily senior nurses meeting patients at high risk of malnutrition and/or dehydration are discussed and nursing staff redeployed at lunch time to provide additional support to these patients

Areas of improvement planned for 2014/15

In 2014/15 we plan to undertake the following to increase our patient satisfaction in relation to our target areas:

- We will feedback all patient survey results (including locally conducted surveys) to all Clinical Business Units during the quarterly Clinical Audit Days, capturing all grades of doctors
- We will install patient information board in our day surgery department that will show patients what will happen before, during and following their procedure
- We will develop plans at the Trust-level and locally (e.g. within specialties) to address specific concerns

How we will monitor our progress

To monitor our progress in achieving these improvements we will:

- Carry out regular audits of our clinical areas to ensure improvements are being sustained;
- Escalate concerns as appropriate
- Undertake frequent surveys of inpatients
- Compare our performance in the July 2014 Picker Institute survey with previous years

3. Clinical effectiveness priority 2014/15: reduce the number of patients who need to be readmitted to hospital

Aim

Our aim for 2014/15 is to reduce the number of patients who need to be readmitted to hospital following a stay in hospital.

Targets for 2014/15

Our targets in relation to the reduction of readmissions are:

- Reduce the number of readmissions within seven days of discharge by 10 percent
- Reduce the number of readmissions within 28 days of discharge by 20 percent

Areas of improvement planned for 2014/15

We plan to implement the following measures in order to meet our targets for reducing readmissions:

- Implementation of standards for effective ward rounds seven days a week in acute medicine
- Review and plan for clinical support service to facilitate seven day working
- Complete a review against the Seven Days a Week[7] standards and develop a robust plan for implementation
- Improve relationships with community health and social care providers
- Real-time reports from CHKS on readmissions
- Use of CQUINs framework to reduce readmissions

[7] The Seven Days a Week standards were developed by NHS England and consist of ten clinical standards to ensure patients receive the best possible care and treatment every day of the week. The standards include: appropriately involving patients, their families and carers, in decisions about treatment; all emergency admissions should be seen by an appropriate consultant within 14 hours of admission; and, patients must have seven-day a week access to diagnostic tests such as x-ray and endoscopy (with varying time-related targets according to the need of the patient).

How we will monitor our progress

To monitor our progress in achieving these improvements we will:

- Monitor ward rounds through the Inpatient Flow Transformation for Excellence work stream with progress reported to the Executive Review Board
- We will apply the Seven Days a Week self-assessment tool (following its release in May 2014), which will be reported to our Quality Board
- The Better Care Fund Steering Group will oversee our improved working with community health and social care providers

Review of services provided by Bedford Hospital NHS Trust

During 2013/14, Bedford Hospital NHS Trust provided 42 relevant health services and sub-contracted 12 relevant health services. A list of all services provided by the Trust is located in Annex 1: Services provided by Bedford Hospital NHS Trust in 2013/14.

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

The income generated by the relevant health services reviewed in 2013/14 represents 100 percent of the total income generated from the provision of relevant health services by Bedford Hospital NHS Trust for 2013/14.

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 2013/14 47 national clinical audits and five national confidential enquiries covered relevant health services that Bedford Hospital NHS Trust provides.

During 2013/14 Bedford Hospital NHS Trust participated in 91 percent of national clinical audits and 100 percent of national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Bedford Hospital NHS Trust was eligible to participate in during 2013/14 are as follows:

- Acute Myocardial Infarction and other ACS (Myocardial Ischaemia National Audit Project (MINAP))
- Adult Critical Care ICNARC National Audit
- Asthma in Children (College of Emergency Medicine)
- Bedfordshire Diabetic Eye Screening Programme
- Bowel Cancer (National Bowel Cancer Audit Programme)

- Cardiac Arrest (National Cardiac Arrest Audit)
- Cardiac Arrhythmia
- Child Health (CHR-UK)
- Coronary Angioplasty (NICOR Adult Cardiac Interventions Audit)
- Elective Surgery (National Patient Reported Outcome Measure (PROMs) Programme))
- Emergency Use of Oxygen (British Thoracic Society)
- Endoscopy Audits – 32 separate national requirements
- Epilepsy 12 (Childhood Epilepsy)
- National Heart Failure Audit
- Inflammatory Bowel Disease
- National Lung Cancer Audit
- Multicentre Appendectomy Audit
- Multicentre Audit of the Management of Acute Pancreatitis
- National Audit for Cardiac Rehabilitation
- National Audit of Intermediate Care
- National Audit of Seizure Management
- National Care of the Dying Audit of Hospitals
- National Comparative Audit of Blood Transfusion – Use of Anti D
- National Comparative Audit of Patient Information and Consent
- National chronic obstructive pulmonary disease (COPD) audit (British Thoracic Society)
- National Diabetes Audit
- National Diabetes In Pregnancy Audit
- National Diabetes Inpatient Audit
- National Emergency Laparotomy Audit
- National Head and Neck Cancer Audit
- National Hip Fracture Database Including Falls and Fragility Fractures
- National Joint Registry
- National Psoriasis Audit
- National Vascular Database
- National Neonatal Audit Programme
- National Oesophago-gastric Cancer Audit
- Paediatric Bronchiectasis Audit (British Thoracic Society)
- Paediatric Diabetes Audit
- Paediatric Intensive Care (PICANet)
- Paracetamol Overdose in Adults (College of Emergency Medicine)
- Percutaneous nephrolithotomy (PCNL) Audit
- Rheumatoid and Early Inflammatory Arthritis
- Severe Sepsis and Septic Shock in Adults (College of Emergency Medicine)
- Severe Trauma (Trauma Audit and Research Network)

- Stroke National Audit Programme (combined Sentinel and Stroke Improvement National Audit Programme)
- UK Carotid Endarterectomy Audit

The national clinical audits and national confidential enquiries that Bedford Hospital NHS Trust participated in, and for which data collection was completed during 2013/14, are listed in Table 4 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 4: Bedford Hospital NHS Trust participation in national clinical audits

National audit	Percentage participation
Acute Myocardial Infarction and other ACS (Myocardial Ischaemia National Audit Project (MINAP))	Ongoing[8]
Adult Critical Care/Intensive Care National Audit and Research Centre	Ongoing
Asthma in Children (College of Emergency Medicine)	100% (29/29) no minimum dataset required
Bedfordshire Diabetic Eye Screening Programme	Ongoing
Bowel Cancer (National Bowel Cancer Audit Programme)	Ongoing
Cardiac Arrest (National Cardiac Arrest Audit)	Ongoing
Cardiac Arrhythmia	Ongoing
Child Health (CHR-UK)	Ongoing
Coronary Angioplasty (NICOR Adult Cardiac Interventions Audit)	Ongoing
Elective Surgery (National Patient Reported Outcome Measure (PROMs) Programme)	Ongoing
Emergency Use of Oxygen (British Thoracic Society)	100% (24/24)
Endoscopy Audits (32 requirements)	(97%) 31/32 separate audits completed Outstanding audit due to reporting system audit tool
Epilepsy 12 (Childhood Epilepsy)	Ongoing
Heart Failure (National Heart Failure Audit)	Ongoing

[8] 'Ongoing' indicates a rolling audit to which we submit data as and when it is appropriate.

National audit	Percentage participation
Inflammatory Bowel Disease	Ongoing
Multicentre Appendectomy Audit	100%
Multicentre Audit of the Management of Acute Pancreatitis	Ongoing
National Audit for Cardiac Rehab (NACR)	Ongoing
National Audit of Seizure Management (NASH)	100% (30/30)
National Care of the Dying Audit of Hospitals (NCDAH)	100% (50/50)
National Comparative Audit of Patient Information and Consent	Commenced following delayed start date
National chronic obstructive pulmonary disease (COPD) audit (British Thoracic Society)	Ongoing
National Diabetes in Pregnancy Audit	Ongoing
National Diabetes Inpatient Audit	100% All eligible cases
National Emergency Laparotomy Audit (NELA)	Ongoing
National Head and Neck Oncology	Ongoing
National Hip Fracture Database including Falls and Fragility Fractures	Ongoing
National Joint Registry	Ongoing
National Lung Cancer Audit	Ongoing
National Paediatric Diabetes Audit	100% (126/126)
National Psoriasis Audit	100% (3/3)
National Vascular Database	Ongoing
Neonatal Intensive and Special Care (NNAP)	Ongoing
National Oesophago-gastric Cancer Audit	Ongoing
Paediatric Intensive Care (PICANet)	Ongoing
Paracetamol Overdose in Adults (College of Emergency Medicine)	100% (39/39) No minimum dataset required
Percutaneous nephrolithotomy (PCNL) Audit	Ongoing
Severe Sepsis and Septic Shock in Adults (College of Emergency Medicine)	100% (38/38) no minimum dataset required
Severe Trauma (Trauma Audit and Research Network)	Ongoing
Stroke National Audit Programme (combined Sentinel and SINAP)	Ongoing

National audit	Percentage participation
UK Carotid Endarterectomy Audit	Ongoing

In 2013/14 Bedford Hospital NHS Trust did not participate in five national audits, identified in Table 5.

Table 5: Bedford Hospital NHS Trust non-participation in national clinical audits

Audit	Reason
National Comparative Audit of Blood Transfusion - Use of Anti D	Resourcing issues
National Audit of Intermediate Care	Clinical Business Unit lead unidentified
Rheumatoid and Early Inflammatory Arthritis	Resourcing issues
National Diabetes Audit	Limited data set - awaiting new database and appointment of new post holder
Paediatric Bronchiectasis Audit (British Thoracic Society)	Unknown

The report of one national clinical audit was reviewed by the provider in 2013/14 and Bedford Hospital NHS Trust intends to take the following actions to improve the quality of healthcare provided, as detailed in Table 6.

Table 6: Bedford Hospital NHS Trust review of national clinical audit and associated actions

National Audit	Actions
Use of Emergency Oxygen (British Thoracic Society)	Oxygen prescribing included in medical staff induction Review arterial blood gases results and document review in healthcare records Ensure oxygen is prescribed on the drug chart Assess impact of e-prescribing Nursing staff to review oxygen on each drug round and sign accordingly Reducing dependency on oxygen according to oxygen saturation/blood gases Review of oxygen requirements on ward round 'Ownership' by Medical Gases Committee

The reports of 49 local clinical audits were reviewed by the Bedford Hospital NHS Trust in 2013/14 and the Trust intends to take the following actions to improve the quality of healthcare provided (Table 7).

Table 7: Local clinical audits and associated actions

Local Clinical Audit	Actions
DNACPR (Do Not Attempt Cardio Pulmonary Resuscitation) Documentation	Amended DNACPR form introduced September 2013 Ongoing Basic Life Support, Immediate Life Support and medical induction training Re-audit planned in 2014/2015
Missed and Omitted Medicines and the Critical Medicines list	Increased availability of Ward Pharmacist Medicines reconciliation improvements made Pharmacists complete prescriptions for medicines patients need to take home Urgent item dispensing Better use of porter delivery cupboards Re-audit planned in 2014/2015
Re-audit of Drug Allergy Documentation	E-prescribing rolled out which provides prompts to complete allergy status General Practitioner (GP) contacted where patients are unable to give information New A&E/AAU admission proforma will have allergy box re-sited on page 2 against drug history information together with tick box options to record whether patient is on Insulin or Warfarin Re-audit planned 2014/2015
Pain Scoring and Inpatient satisfaction with Pain Control	Ongoing education sessions to include prescription of PRN ('give as needed') analgesia Acute Analgesia Guidelines have been drafted Re-audit planned in 2014/2015
Re-audit of Patient At Risk (PAR) Scoring	Ongoing training in PAR scoring Amend Escalation Policy of PAR 1 and 2 and introduction of revised Treatment Escalation Policy Reviews underway of observation form to enable seamless documentation including option for senior clinician to record if patient is not for escalation Re-audit planned in 2014/2015

Local Clinical Audit	Actions
Upper Gastrointestinal (GI) Bleeding	Introduction of GI Bleed guideline
Re-Audit Community Acquired Pneumonia (CAP)	Review of introduction of a Pneumonia Care Bundle Participation in national audit 2014/2015
Re-Audit of Oxygen Therapy	Ongoing education of oxygen therapy Respiratory Nursing team delivered ward based teaching sessions Participation in national audit on Emergency Oxygen
Re-audit of the Early Management of Oncology Patients with Febrile Neutropenia	Discussed at Anglia Cancer Network Acute Oncology Group Discussions between Oncology and Pharmacy regarding the use of a patient group directive to allow nurses to give the first dose of Tazocin A pathway guidance pack is being developed Re-audit planned in 2014/2015
Day Case Pacing Service	Patient satisfaction survey planned Business plan submitted for additional portering support to enable priority/advanced warning to Radiology of timing and number of patients needing a chest x-ray
Management of Acute Bacterial Meningitis in Adults	Local guideline in development
Utilisation of Emergency Theatre	Foundation Doctors (FY, second year) or Specialty Registrar (formerly Senior House Officer) on night shift review patients booked in emergency folder On call Anaesthetist and Surgical Registrar discuss lists at 8am
Sterilising of Instruments sets	Matron round before list commences Pre-operative check list signed off after preparation complete Training document updated Theatre Porter trained on identification of missing filters Introduction of documentation to record filter checks Continuous auditing of the World Health Organisation (WHO) checklist Instrument sterility checklist poster is displayed in instrument store and all theatre prep rooms Weekly Matron's rounds introduced which include observation checks and audits of documentation and

Local Clinical Audit	Actions
	performance of WHO checklists
Caesarean section pathway and discussion on cardiotacography (CTG)	Two consultants and two midwives meet weekly to discuss patients who have had a previous caesarean section for their suitability for vaginal birth after caesarean (VBAC) and to discuss any patient concerns
Situation, Background, Assessment, Recommendation (SBAR) audit	All Handover sheets confirming SBAR are signed
Neonatal Antibiotics	East of England Network guidelines for managing neonatal sepsis implemented September 2013 Re-audit planned in 2014/2015
Paediatric syncope	Guideline being drawn up for managing syncope in childhood Re-audit planned in 2014/2015
Retinopathy of Prematurity (ROP)	Diary on Neonatal Unit (NNU) alerts Ophthalmology staff of name of baby due for their first retinal check Ophthalmology staff now have access to BadgerNet[9] to enable updating following ROP screening
Consent in Gynaecology	Documentation in place to support that all patients who require a patient leaflet have received one FY trainees checks carried out to confirm which procedures they are able to consent Re-audit planned in 2014/2015

[9] BadgerNet is a live patient data management system for maternity, paediatric and neonatal critical care

National Confidential Enquiries

The national confidential enquiries that Bedford Hospital was eligible to participate in during 2013/14 are as follows:

- Lower Limb Amputation
- Tracheostomy Management
- Gastrointestinal Bleeding
- Subarachnoid Haemorrhage
- Alcohol Related Liver Disease (Organisational data)

The national clinical audits and national confidential enquiries that Bedford Hospital participated in, and for which data collection was completed during 2013/14, 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 8)

Table 8: Bedford Hospital NHS Trust participation in national confidential enquiries

National Confidential Enquiry	Percentage participation
Lower Limb Amputation	62.5%
Tracheostomy Management	100%
Gastrointestinal bleeding	0%
Subarachnoid Haemorrhage	100%
Alcohol related liver disease (Organisational data)	100%

Participation in clinical research

The number of patients receiving relevant health services provided or sub-contracted by Bedford Hospital NHS Trust in 2013/2014 that were recruited during that period to participate in research approved by a research ethics committee, was 494. This was an increase from 486 from the previous year.

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. Active participation in research also contributes to improved outcomes for our patients. Our clinical staff

stay up to date with the latest treatment possibilities and are encouraged to participate in clinical research.

Bedford Hospital NHS Trust was involved in conducting 30 clinical research studies in Cancer, Cardiology, Stroke, Elderly Care, Ophthalmology, Neurology, Emergency Medicine, Critical care, Oral and Maxillofacial Surgery, Gastroenterology, Dermatology, Respiratory Medicine, Diabetes, Rheumatology and Genitourinary Medicine (GUM) during 2013/2014.

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 100 of clinical staff participating in research approved by the Research Ethics Committee at Bedford Hospital NHS Trust during 2013/14. The research covered 15 medical specialties.

In the last three years, 132 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. Our engagement with clinical research also demonstrates our commitment to testing and offering the latest medical treatments and techniques.

Our staff are also involved in number of research projects leading to postgraduate degrees, including MSc and PhD research, in collaboration with Cranfield University, the University of Hertfordshire and the University of Bedfordshire. The Trust has a memorandum of understanding with Cranfield University. This had provided significant research activity and a number of patents. The Trust is also involved in making research grant applications in collaboration with Cranfield University.

CQUIN framework

A proportion of Bedford Hospital NHS Trust income in 2013/14 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 payment framework. Further details of the agreed goals for 2013/14 and for the following 12 month period are available online at: https://www.innovation.nhs.uk/pg/cv_blog/content/view/40573/network

In 2013/14 nine CQUINs applied to the Trust (listed in Table 9).

Four were mandated nationally (highlighted in blue in Table 9):

- Patient Experience (1.1, 1.2 and 1.3)

- NHS Safety Thermometer (2.1 and 2.2)
- Aware and diagnosis for dementia (3.1, 3.2 and 3.3)
- Venothromboembolus (VTE) (4.2)

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

- Enhanced Recovery Programme (5.1 to 5.4)
- ePrescribing (6)
- Paediatric Patient Experience (7)
- Improving stroke care (8)
- End of Life care (9)

Table 9: Bedford Hospital NHS Trust achievement against 2013/14 CQUINs

Indicator identifier	Description	Overall Achievement (%) for 2013/14
1.1	**Friends & Family Test (FFT)Phased Expansion**: Delivery of FFT to Maternity Services	**100%**
1.2	**FFT Increased Response Rate**: Acute in-patient and A&E	**100%**
1.3	**FFT Staff Improved Performance**: Staff Friends & Family Test	**0**
2.1	**NHS Safety Thermometer**: Reduction in Pressure Ulcers	**0**
2.2	**NHS Safety Thermometer**: Reduction in Falls	**100%**
3.1	**Dementia**: Find, Assess, Investigate & Refer 90 percent of eligible inpatients	**100%**
3.2	**Dementia**: Clinical leadership & staff training	**100%**
3.3	**Dementia**: Supporting Carer's of People with Dementia through a Carer's Audit	**100%**
4.1	**Venous thromboembolism (VTE):** Risk Assessment 95% of Adult in-patients	**100%**
4.2	**VTE Root Cause Analysis:** RCA for all Hospital Acquired Thrombosis	**100%**
5.1	**Enhanced Recovery Programme (ERP) Database:** Reporting on the National database	**Projected 100%**
5.2	**ERP**: Admission on day of Surgery for 805 of eligible elective procedures	**Projected 100%**
5.3	**ERP**: Goal Directed Fluid Therapy (GDFT) ≥90% of eligible elective procedures receiving GDFT	**Projected 100%**
5.4	**ERP**: Reduction in Length of Stay of eligible elective procedures	**33%**
6.	**EPrescribing:** Implementation of electronic prescribing	**100%**
7.	**Paediatric Patient Experience:** Maintain 10% response rate & 10 point improvement for Net Promoter	**75%**
8.	**Improving Stroke Care:** 90% of Stroke patients staying 90% of their time on Acute Stroke Unit	**100%**
9.	**End of Life:** Registration of COPD, Cardiac and Dementia patients identified in last 12 months of life to the PEPs register	**100%**

Care Quality Commission (CQC) registration and compliance

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

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

The Care Quality Commission has taken enforcement action against Bedford Hospital NHS Trust during 2013/14.

The CQC conducted an unannounced inspection of Bedford Hospital NHS Trust in July 2013. This inspection was carried out in response to concerns that one or more of the essential standards of quality and safety were not being met. During this inspection CQC examined nine standards. The CQC found that the Trust was compliant with Outcome 10 (safety and suitability of premises). The Trust was required to take action in relation to the following standards:

- Outcome 1: Respecting and involving people who use services
- Outcome 4: Care and welfare of people who use services
- Outcome 5: Meeting nutritional needs
- Outcome 6: Cooperating with other providers
- Outcome 7: Safeguarding people who use services from abuse

The CQC took enforcement action with respect to three standards:

- Outcome 13: Staffing
- Outcome 14: Supporting workers
- Outcome 16: Assessing and monitoring the quality of service provision

Following this inspection the Trust implemented an aggressive programme of change and set challenging targets to address the CQC's concerns by the end of October 2013.

In November 2013 the CQC carried out a re-inspection to check whether the Trust had taken the necessary action to meet the essential standards that were not being met in July 2013. The CQC found that the Trust was meeting all standards with the exception of Outcome 16 (Assessing and monitoring the quality of service provision). In this regard, the CQC found that we had systems in place to identify, assess and manage risks to the health, safety and welfare of people who use the

service but further work was required to ensure these systems were fully embedded throughout the Trust. This was deemed to have a minor impact on people who use our hospital.

We have an ongoing programme to ensure that our assessment and monitoring systems are fully embedded across the Trust and we have been providing the CQC with monthly progress reports. In March 2014, the CQC informed the Trust it was satisfied with the progress made in relation to Outcome 16.

In order to monitor these changes we developed a programme to undertake quality reviews of all wards (the Quality Review Scheme (QRS)). During a Quality Review Scheme assessment a team of assessors carries out an unannounced assessment of a ward to identify areas of good practice and areas in need of improvement in order to the ward to meet the CQC's essential standards.

An assessment team typically includes an external partner (for example, a clinician from a Clinical Commissioning Group), a patient representative (for example, a member of our Patient Council or a representative from Healthwatch), and an internal representative (for example, a senior nurse, executive or consultant). Feedback is immediately provided to the ward, matron and clinical business unit, and actions required to address any areas of concern are implemented.

The first round of QRS ward assessments took place in October 2013. Following these assessments nurse mentors and other clinical support were provided to wards identified where further support was needed. Following the second round of assessments in February 2014, assessors found that improvements in standards had largely been maintained.

Data quality

Bedford Hospital NHS Trust submitted records during 2013/14 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:

- 99.5 percent for admitted patient care;
- 99.7 percent for outpatient care; and
- 98.2 percent for accident and emergency care.

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

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

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

- Increased use of the national Summary Care Record and Patient Demographic Service to check patient demographics;
- Improvements to the sign-off mechanism for all hospital deaths;
- The Data Quality Group will meet on a monthly basis with key staff of the hospital to monitor and improve all data quality work streams (The Data Quality Group reports to the Information Governance Board); and
- Continued development of clinical coders to enable achievement of Professional Association of Clinical Coders (PACC) qualification.

Information Governance Toolkit

Bedford Hospital NHS Trust Information Governance Assessment Report overall score for 2013/14 was 71 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.

Part 3: Overview of the quality of our care in 2013/14

Part 3 of our 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 6.

Figure 6: 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

This year the Department of Health identified sixteen quality indicators for inclusion in Quality Accounts, some of which only apply to specific types of provider (e.g. ambulance trusts, mental health trusts or acute trusts).

Our performance against 2013/14 quality indicators

The eight Quality Account indicators that apply to Bedford Hospital NHS Trust are:

- Summary Hospital-Level Mortality Indicator (SHMI)

  - SHMI banding
  - Percentage of patient deaths with palliative care coded at either diagnosis or specialty level
- Patient Reported Outcome Measures (PROM) scores 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 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
- Percentage of staff who would recommend the Trust to friends or family needing care

Summary Hospital-Level Mortality Indicator (SHMI)

NHS Outcomes Framework Domains:

1 – Preventing people from dying prematurely
2 – Enhancing the quality of life for people with long-term conditions

	2011/12	2012/13	2013/14
Bedford Hospital NHS Trust	104.5 Band 2 'As expected' 27.2% Palliative Care	110.03 Band 2 'As expected' 21.4% Palliative Care	110.07 Band 2 'As expected' 21.8% Palliative Care
National average	100.00	100.00	100.00
Best performing Trust	71.02 Band 3 'Lower than expected' 16.4% Palliative Care	65.23 Band 3 'Lower than expected' 10.5% Palliative Care	62.59 Band 3 'Lower than expected' 6.1% Palliative Care
Worst performing Trust	124.75 Band 1 'Higher than expected' 15.3% Palliative Care	116.97 Band 1 'Higher than expected 12.5% Palliative Care'	115.53 Band 1 'Higher than expected' 12.8% Palliative Care

Notes:

2011/12 data = April 2011 to March 2012 (published October 2012)

2012/13 data = April 2012 to March 2013 (published October 2013)

2013/14 data = July 2012 to June 2013 (published January 2014)

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

- Processes are in place to review all deaths and lessons are learnt through the review process

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

- Reviewing mortality data and involving clinicians in reviewing each patient death.

Patient Reported Outcome Measures: Groin hernia surgery

NHS Outcomes Framework Domain:

3 – Helping people to recover from episodes of ill health or following injury

Groin hernia surgery	2011/12	2012/13	2013/14
Bedford Hospital NHS Trust	0.103	0.094	N/A
NHS England average	0.087	0.085	0.086
Best performing Trust	Not available	Not available	Not available
Worst performing Trust	Not available	Not available	Not available

Notes:

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

2011/12 = Final data for period April 2011 to March 2012

2012/13 = Provisional data (available February 2014) for period April 2012 to March 2013

2013/14 = Provisional data (available February 2014) for period April 2013 to September 2013

N/A = Not Applicable due to too few modelled records to calculate

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

- The Trust offers both open and laparoscopic inguinal hernia repair and exceeds outcomes from NHS England average

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

- Improving our data capture.

Patient Reported Outcome Measures: Varicose vein surgery

NHS Outcomes Framework Domain:

3 – Helping people to recover from episodes of ill health or following injury

Varicose vein surgery	2011/12	2012/13	2013/14
Bedford Hospital NHS Trust	-7.58*	N/A**	N/A
England average	-7.90	-8.37	-9.46
Best performing Trust	Not available	Not available	Not available
Worst performing Trust	Not available	Not available	Not available

Notes:

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

2011/12 = Final data for period April 2011 to March 2012

2012/13 = Provisional data for period April 2012 to March 2013 (available February 2014)

2013/14 = Provisional data for period April 2013 to September 2013 (available February 2014)

N/A = Not Applicable due to too few modelled records to calculate

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

- The Trust undertakes less invasive treatments for varicose veins such as radiofrequency ablation and ultrasound-guided foam sclerotherapy in line with NICE guidance.
- *although 2011/12 adjusted outcome is marginally worse than NHS England (statistically insignificant) 91 percent of patients report improvement compared to 83 percent for NHS England.
- **2012/3 provisional data is modelled on 26 records and therefore cannot be formally reported. However average Aberdeen VV score for these patients is -9.99 (improved) which is better than NHS England average. The final data set may include more than 30 records.

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

- We will maintain our performance and ensure all relevant patients treated for varicose veins are captured.

Patient Reported Outcome Measures: Hip replacement surgery

NHS Outcomes Framework Domain:

3 – Helping people to recover from episodes of ill health or following injury

Hip replacement surgery*	2011/12	2012/13	2013/14
Bedford Hospital NHS Trust	20.51	21.49	N/A
England average	20.08	21.32	21.61
Best performing Trust	Not available	Not available	Not available
Worst performing Trust	Not available	Not available	Not available

Notes:

Adjusted average health gain data (Oxford Hip Score)

2011/12 = Final data for period April 2011 to March 2012

2012/13 = Provisional data for period April 2012 to March 2013 (available February 2014)

2013/14 = Provisional data for period April 2013 to September 2013 (available February 2014)

N/A = Not Applicable due to too few modelled records to calculate

* 2011/2 data is for all hip replacements; 2012/3 onwards splits for primary and revision hip. Primary data is quoted for that period.

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

- Oxford Hip Score outcomes are on a par with NHS England average.

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

- Focus on enhanced recovery; however clinical outcomes according to National Joint Registry are excellent.

Patient Reported Outcome Measures: Knee replacement surgery

NHS Outcomes Framework Domain:

3 – Helping people to recover from episodes of ill health or following injury

Knee replacement surgery*	2011/12	2012/13	2013/14
Bedford Hospital NHS Trust	14.53	16.62	N/A
England average	15.15	16.01	16.74
Best performing Trust	Not available	Not available	Not available
Worst performing Trust	Not available	Not available	Not available

Notes:

Adjusted average health gain data (Oxford Knee Score)

2011/12 = Final data for period April 2011 to March 2012

2012/13 = Provisional data for period April 2012 to March 2013 (available February 2014)

2013/14 = Provisional data for period April 2013 to September 2013 (available February 2014)

N/A = Not Applicable due to too few modelled records to calculate

*2011/2 data is for all knee replacements; 2012/3 onwards splits for primary and revision knees. Primary data is quoted for that period.

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

- Oxford Knee Score outcomes are on a par with NHS England average.

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

- Focus on enhanced recovery; however clinical outcomes according to National Joint Registry are excellent.

Emergency readmissions to the hospital within 28 days of discharge

NHS Outcomes Framework Domain:

3 – Helping people to recover from episodes of ill health or following injury

	2011/12	2012/13	2013/14
0 to 14 years of age	7.02%*	9.6%	9.25%
Over 15 years of age	9.98%*	10.8%	11.14%

Notes:

*Health and Social Care Information Centre data only available for 2011/12 when the age categories were 0 to 15 years and over 16 years

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

- Close working with primary care and social services.

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

- Improving our management of complex discharges by joint working with other agencies.

Responsiveness to the personal needs of patients

NHS Outcomes Framework Domain:

4 – Ensuring that people have a positive care experience

	2011/12	2012/13	2013/14
Bedford Hospital NHS Trust	75.6%	73.9%	Not available
National average	75.6%	76.5%	Not available
Best performing Trust	87.8%	88.2%	Not available
Worst performing Trust	67.4%	68.0%	Not available

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

- Data supplied by Health and Social Care Information Centre for indicator 4b from National Inpatient Survey measuring patient experience as of June 2013. 2013/14 data is not available until June 2014.

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

- Providing patient information leaflets for patients on discharge relevant to their circumstances and which inform them of their medicines.

Percentage of admitted patients who were risk assessed for venous thromboembolism

NHS Outcomes Framework Domain:

5 – Treating and caring for people in a safe environment and protecting them from avoidable harm

	2011/12	2012/13	2013/14
Bedford Hospital NHS Trust	92.5%	95.7%	95.9%
National average			
Best performing Trust	Not available	100%	100%
Worst performing Trust	Not available	69.8%	90.8%

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

- The 2013/14 data represents March 2013 to January 2014 (incomplete financial year)

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

- Implementing an e-Prescribing and Medicines Management (ePMA) system that requires completion of VTE assessment before prescribing allowed; and
- Continued awareness raising of the importance of VTE assessment amongst junior staff at induction.

Rate of *Clostridium difficile* infections

NHS Outcomes Framework Domain:

5 – Treating and caring for people in a safe environment and protecting them from avoidable harm

	2011/12	2012/13	2013/14
Bedford Hospital NHS Trust	23.1	13.5	Not available
National average	22.2	17.3	Not available
Best performing Trust	0	0	Not available
Worst performing Trust	51.2	30.6	Not available

Note: All data reflect number of cases per 100,000 bed days

Data provided by Public Health England. No data available for 2013/14.

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

- Continuous and sustained improvements in our infection control practices.

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

- Implementing a new antibiotic policy and undertaking a root cause analysis for each case to maximise learning; and
- Undertaking a root cause analysis for each case to maximise learning.

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

NHS Outcomes Framework Domain:

5 – Treating and caring for people in a safe environment and protecting them from avoidable harm

	2011/12	2012/13	2013/14
Bedford Hospital NHS Trust	3.78 Incidents reported per 100 admissions 0.017 Involving severe harm or death per 100 admissions	5.09 Incidents reported per 100 admissions 0.012 Involving severe harm or death per 100 admissions	6.92 Incidents reported per 100 admissions* (April 2013 – March 2014)
National average	4.64 Incidents reported per 100 admissions 0.042 Involving severe harm or death per 100 admissions	5.26 Incidents reported per 100 admissions 0.042 Involving severe harm or death per 100 admissions	7.90 Incidents reported per 100 admissions** (April – Sept 2013)
Best performing Trust	0.9 Incidents reported per 100 admissions 0 Involving severe harm or death per 100 admissions	1.7 Incidents reported per 100 admissions 0 Involving severe harm or death per 100 admissions	Not available
Worst performing Trust	21.7 Incidents reported per 100 admissions 4.5 Involving severe harm or death per 100 admissions	31.0 Incidents reported per 100 admissions 3.5 Involving severe harm or death per 100 admissions	Not available

Note:

*Data covers period April 2013 to March 2014

**Date covers period April 2013 to September 2013

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

- Data from Health and Social Care Information Centre sourcing National Reporting and Learning Service is not yet available.

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

- Reporting incident rates to our Quality Board on a monthly basis; and
- Employing a Patient Safety Coordinator to lead improvement work in incident reporting and management.

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

NHS Outcomes Framework Domain:

4 – Ensuring that people have a positive care experience

	2011	2012	2013
Bedford Hospital NHS Trust	71%	63%	36%
National average	62%	63%	64%
Best performing Trust	89%	Not available	Not available
Worst performing Trust	33%	Not available	Not available

Data from Picker Institute Staff Survey

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

- Last two years data is from Picker Institute from national staff survey related to Friends and Family Test.

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

- Giving staff more opportunities to feedback their experience of working at the Trust enabling us to be more responsive to staff needs and concerns.

Quality highlights of 2013/14

Over the last year we have made significant improvements in many areas of our organisation to improve outcomes for patients. The following sections provide some of the notable highlights.

Reducing the severity of falls

A patient falling is the most common patient safety incident reported to the National Reporting and Learning System (NRLS) (part of the former National Patient Safety Agency) from inpatient services in England and Wales.

When someone falls it can be difficult to determine whether it was a simple trip or slip, or whether that individual was dizzy and fainted or collapsed. Most falls are reported as causing no or low harm, but some may result in significant injury or death. Up to 90 percent of patients who fracture their neck of femur[10] fail to recover to their previous level of mobility or independence (National Patient Safety Agency, 2007). Table 10 shows the definitions of severity for patient safety incidents adapted to falls.

Table 10: NPSA definitions of severity adapted to falls

Term	Definition adapted to falls
No harm	Where no harm came to the patient
Low harm	Where the fall resulted in harm that required first aid, minor treatment, extra observation or medication
Moderate harm	Where the fall resulted in harm that was likely to require outpatient treatment, admission to hospital, surgery or a longer stay in hospital
Severe harm	Where permanent harm, such as brain damage or disability, was likely to relate from the fall
Death	Where death was the direct result of the fall

Source: National Patient Safety Agency (2007)

[10] A fractured neck of femur (frequently written as #NOF in medical notes) is when the top part of the hop bone is broken. This type of fracture usually requires an operation to repair the break using one of three methods. As a fractured neck of femur can be very slow to repair without surgery - often not repairing at all – nearly all patients benefit from having surgery to repair the break.

Bedford Hospital NHS Trust reported 750 inpatient falls during 2013/14, compared with 746 in 2012/13. All falls are reported via the hospital incident reporting software.

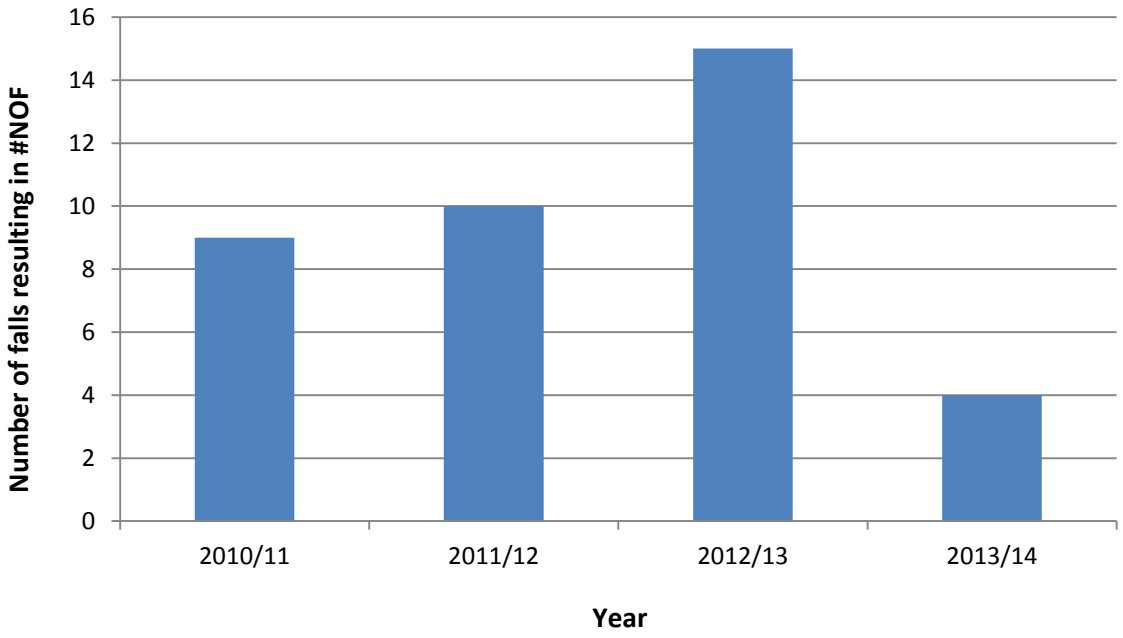
Most (60 percent) reported inpatient falls during 2013/14 resulted in no harm to the patient. Table 11 shows the number of reported inpatient falls by severity.

Table 11: Bedford Hospital NHS Trust Inpatient falls during 2013/14

None (no harm)	Minor (low harm)	Moderate harm	Severe harm	Death
449	283	14	4	0

The case fatality rate for inpatients sustaining a fractured neck of femur following a fall was zero for 2013/14. Four inpatients sustained a fractured neck of femur as a result of falling, which shows a significant improvement compared to previous years (Figure 7).

Figure 7: Number of patient falls resulting in a fractured neck of femur between 2010/11 and 2013/14



Two patients attending the hospital for outpatient appointments also fell on the premises and sustained a fractured neck of femur. Both patients had reparative surgery and were discharged home.

The reduction of falls resulting in harm remains a high priority for Bedford Hospital and a key indicator of quality care.

In order to reduce the number of inpatient falls resulting in severe harm we have carried out the following actions over the last year:

- Increased nurse numbers on wards with patients at higher risk of falling;
- Invested in low-level beds and wander guards;
- Implemented the Royal College of Physicians FallSafe Care Bundle;
- Included data on falls in our ward quality dashboards; and
- Introduced supervisory ward sisters with specialist knowledge of falls.

Improved services for patients with dementia: the Butterfly Scheme, cognitive skills training and environmental improvements

In May 2013 we launched the Butterfly Scheme. The Scheme involves the identification of patients with a dementia diagnosis with a coloured butterfly on or near their bed, allowing staff to quickly identify patients with dementia and respond appropriately. We are planning to extend the Butterfly Scheme to incorporate patients with cognitive impairment who do not have a dementia diagnosis. Initial feedback from carers of patient with dementia has been positive.

This year we also began providing cognitive skills training to staff working in areas where most of our dementia patients are cared for. The aim of the training is to help staff to understand how best to occupy and support patients with dementia. Using these techniques can lead to a reduction in the use of antipsychotic medication and reduces the incidences of challenging behaviour from patients. Improving the cognitive skills of patients with dementia also reduces the volume of falls experienced by this particularly vulnerable group as the provision of structured activities tends to reduce the tendency of patients to wander around the ward area.

In 2013/14, we began to make substantial improvements to the ward environments for our patients with dementia. Working in partnership with Bedford Borough Council we have been successful in securing £463k of funding from the Department of Health to make improvements to the ward environments for two wards at Bedford Hospital. Bedford Borough Council has also been awarded funding to undertake environmental improvements across a number of their sites.

The project aims to create synchronised, dementia-friendly environments across both organisations inlight of an increasing body of evidence that demonstates that appropriately designed environmental can greatly increase the outcomes for patients with dementia and reduce the negative effects of long-term stays in acute settings (e.g. challenging behaviour, use of anti-psychotic medications).

Our improvements include installation of non-shiny flooring, dementia-friendly signage and way finding, recognisable toilet and wash areas and a lounge area to allow patients to relax away from the ward. Thanks to a generous donation from Bedford Hospital Charities we have been able to purchase furniture for the ward areas that is less “clinical” in appearance.

The building work is complete in one of our wards and we anticipate the second ward will be completed in August 2014.

Clinical Pathology Accreditation

Pathology services at Bedford Hospital NHS Trust are provided by Guy's and St Thomas' Pathology Service (GSTS Pathology). GSTS Pathology provides a high-quality laboratory service and has seen numerous achievements in 2013/14.

Microbiology and Clinical Biochemistry services both had successful Clinical Pathology Accreditation (CPA) surveillance visits. Assessors complimented these services in numerous areas for demonstrating best practice. For example, Microbiology was commended for the standardisation of its reporting protocols.

Cellular Pathology underwent its second CPA visit and gained full accreditation with minimal non-compliances.

The Haematology service continued to work to the quality management system required to attain full CPA and is awaiting the outcome of the clinical haematology reviews conducted by the Trust.

The Blood Transfusion service underwent a Medicines and Healthcare Products Regulatory Agency (MHRA) inspection. Only four minor areas of non-compliance were identified and, once addressed, the service was granted full MHRA accreditation.

Looking forward, GSTS Pathology aims to achieve ISO 15189 certification in 2014 and is undertaking a comprehensive gap analysis to ensure this is aim is realised (ISO 15189 is an international standard which identifies particular requirements for quality and competences in medical laboratories).

Oncology services: the Primrose Unit

Bedford Hospital has established a busy and productive cancer research Unit. It consists of two National Cancer Research Network (NCRN) funded nurses, an independent research manager and a consultant oncologist with Professorship at Cranfield University, who has established formal research links with Cranfield University and Cranfield Business School. The Unit regularly hosts postgraduate students from Cranfield University undertaking audits and research projects.

The Primrose Unit is a contributor to a wide range National Cancer Research Network studies and was the UK's highest contributor to the DietcompLy study (274 patients registered). The Unit also designed, conducted and published six of its own studies including the successful "Pomi-T" Study (Figure 8).

Figure 8: The Pomi-T Study

The Pomi-T Study

Men with prostate cancer usually exhibit higher than normal levels of a protein produced in the prostate gland. The Pomi-T study was a clinical trial backed by the UK government that sought to establish the effect of food rich in polyphenols (such as pomegranate) on cancer progression markers.

The study involved 203 men with prostate cancer being treated at Bedford Hospital. The men were randomly split into two groups. One group was given a unique food supplement - named Pomi-T - made from pomegranate, green tea, turmeric and broccoli. The second group was given a placebo.

After six months, the men in the group given the Pomi-T supplement showed an average protein increase of 15% compared with 78% in the group given the placebo.

This was the first clinical trial that firmly established the limiting-influence of polyphenol-rich foods on markers of cancer progression.

Complaints

Our Complaints Department has undertaken several changes over the course of the last year. In order to understand where the department needed to improve we commissioned a peer review by another Trust and several external audits. We also undertook an internal review of processes and standard operating procedures.

There has been a substantial rise in formal complaints and concerns raised with our PALS department. Over the course of 2013/14 we received 41 percent more complaints compared to 2012/13. However, we closed 75 percent more complaints than the previous year (Table 12).

Table 12: Bedford Hospital NHS Trust opened and closed complaints in 2012/13 and 2013/14

	2012 / 13		2013 / 14	
	Opened	**Closed**	**Opened**	**Closed**
April	22	25	21	32
May	13	4	39	26
June	18	22	32	30
July	27	17	33	52
August	14	19	23	30
September	21	12	18	33
October	15	11	24	25
November	24	14	25	31
December	15	11	22	22
January	18	17	25	21
February	13	33	20	22
March	24	34	23	25
TOTAL	**224**	**219**	**305**	**349**

The main themes of the complaints we received in 2013/14 were:

- Lack of information given to patients
- Attitude of staff towards patients
- Availability/timing of pain relief
- Communication between staff/departments
- Staff providing conflicting information to patients

Over the course of 2013/14 we have successfully:

- Cleared a legacy group of complaints;
- Made changes to the overall complaints process which has improved how we how we process and respond to complaints, engage with the complainant and agree resolutions;
- Improved how we share learning from complaints across clinical business units (CBU);
- Strengthened working relations within the Trust by, for example, including our Patient Experience Lead in the complaints process; and
- Introduced complaints training for all staff.

Where we have improved

The Trust has made wide-ranging changes to both its service provision and clinical models of care; and the way in which it monitors the quality of service provision across wards and departments. These improvements followed two significant issues in summer 2013. Firstly the withdrawal of trainee doctors from the paediatric department by Health Education England and the General Medical Council following concerns around supervision; and secondly, a highly critical Care Quality Commission report which raised serious concerns around the Trust's compliance against essential standards of care.

The Trust has learnt a great deal from these incidents and our staff have worked hard to ensure that all issues raised have been addressed and that robust systems are in place to ensure similar failings cannot happen again.

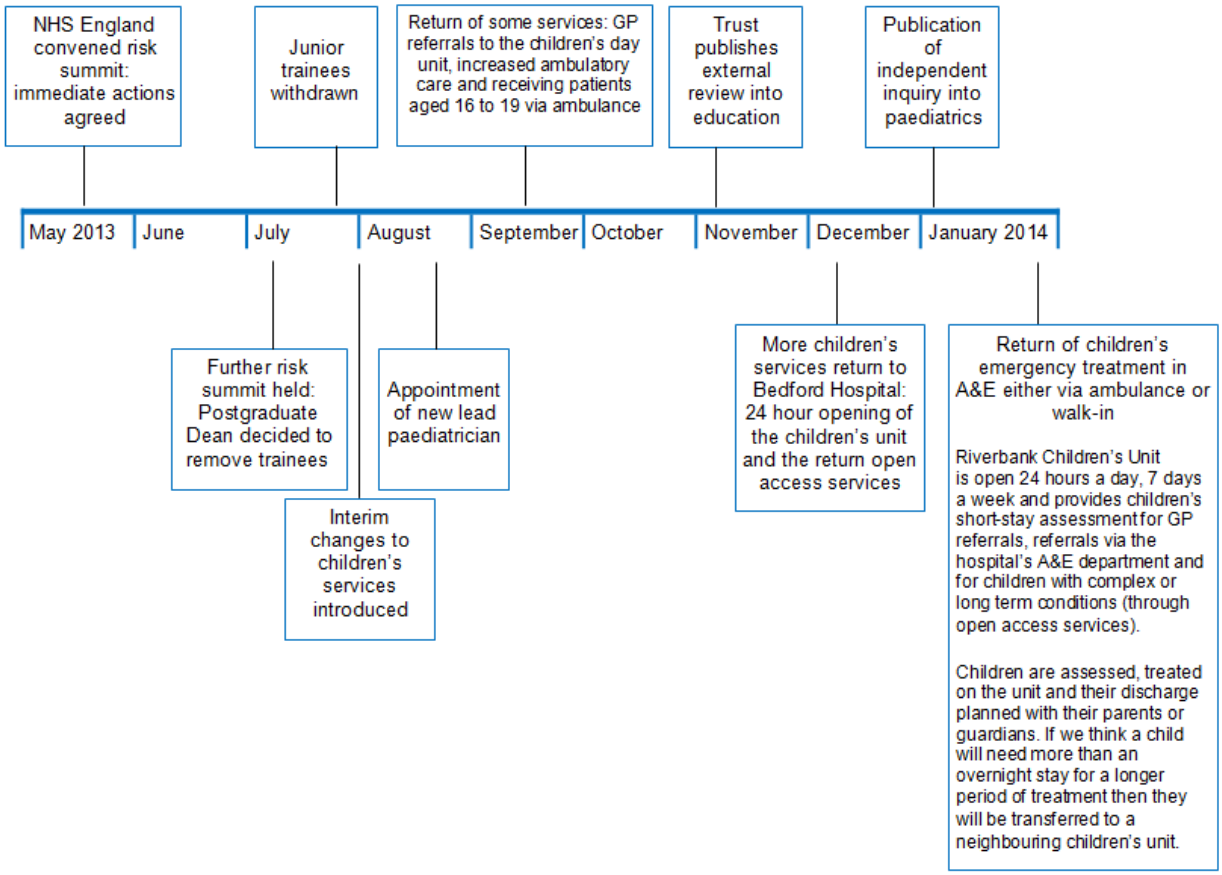
Supervision of trainee paediatric doctors

In July 2013, some children's services were temporarily suspended at Bedford Hospital following the removal of a number of trainee doctors from the department. The decision to remove the trainees was taken by Health Education East of England (HEEoE) and the General Medical Council (GMC), after concerns had been raised about whether these junior medical staff had received appropriate supervision and support.

The decision by HEEoE and the GMC triggered a series of multi-agency and health partner 'risk summits' to examine how service continuity could be maintained for local families. The Trust was unable to recruit locum consultant paediatricians quickly enough to enable all children's services to continue to be provided, so the decision was taken at the risk summit to temporarily suspend provision of inpatient paediatric care, paediatric A&E and open access services. These were re-provided by neighbouring hospitals.

The Trust's immediate priority was to secure adequate consultant staff to ensure children's services could be safely re-provided. An experience consultant paediatrician and clinical lead joined the department to review the clinical care models and ensure that services were modern, safe and fit for purpose when they returned. Over the following five months, the Trust recruited five further paediatricians and returned children's services safely, and to a new, best practice standard. A timeline of events between July 2013 and January 2014 is provided in Figure 9.

Figure 9: Timeline of events between July 2013 and January 2014



The Trust commissioned two external reports into medical education standards and into the paediatric department to ensure all issues could be identified and addressed, openly and transparently. These documents are available on the Trust's website and have been discussed at public meetings.

We recognise the anxiety and distress caused to local families by the service changes and continues to work to rebuild the confidence of the local community, through increased openness, transparency and public involvement across its activities. The following paragraphs present a summary of the actions we have taken to improve our staffing levels, the support we offer our staff, our governance structures and how we respond to children and families who use our paediatrics department.

Staffing

- We now have consultant delivered care with resident consultants between 9am and 9.30pm, seven days a week. To achieve this we increased our number of consultants to eight.
- We have trained all consultants in clinical and education supervision.
- Increase in establishment of medical and nursing staff in paediatrics with individual personal development plans aligned to clinical service delivery.
- We have clarified the roles and responsibilities for consultants working within each area of the paediatric department (e.g. outpatients, neonatal unit).

Supporting workers

- We have improved the clinical leadership within the department by appointing an additional strategic clinical lead.
- We have strengthened our induction process and our continued teaching programme within department is aligned to trainees' curricula.
- We ensure our rotas allow the release of staff for external training.
- We have feedback meetings with the trainees to systematically share lessons learnt from serious incidents, incidents and clinical issues.
- Trainees are represented at our departmental management meetings.
- The medical education structure across the Trust has been strengthened and includes regular independent meetings of the Director of Medical Education and trainees.

Governance

- Clinical governance structures within the department have been strengthened to enable the systematic capture, reporting, escalation and management of risk.
- Our Trust Board has a standing agenda item each month to discuss medical education across the Trust, including the paediatrics department.
- Our paediatrics risk register discussed monthly within the department and upwardly reported to the Trust's Risk and Compliance Board and Quality Board

Responding to people who use our services

- We have established the Riverbank Family Focus Group. This group meets quarterly and any parents or carers of children who use our services may attend, along with representatives from Health Watch and Bedford Borough Parent Carer's Forum. The purpose of the Riverbank Family Focus Group is to give people who use our services, whether it be on one occasion (e.g. a child having one-off surgery) or frequently (e.g. a child with open-access to the ward), the opportunity to provide feedback on the quality of the care and treatment we provide. This feedback is invaluable in ensuring we continue to meet the needs of our patients, their families and carers.
- We receive regular feedback from children and their families through our Friends and Family Test.
- On Riverbank Ward we have installed a suggestions box and compliments notice board, designed to allow children and their families to let us know how they have found their experience in hospital.
- To communicate the changes we make in response to feedback from children, families and carers we have a "You Said, We Did" notice board on Riverbank Ward.

Compliance with Care Quality Commission standards of care and safety

Please refer to the section on Care Quality Commission (CQC) registration and compliance on page 43.

Annex 1: Services provided by Bedford Hospital NHS Trust in 2013/14

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 Guy's and St Thomas' NHS Foundation Trust
** 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: Statements from commissioners, Healthwatch, Health and Wellbeing Board and Overview and Scrutiny Committee

Annex 3: Statement of directors' responsibilities

Annex 4: External audit limited assurance report

Annex 5: Acronyms and abbreviations

A&E	Accident and Emergency
AAU	Acute Assessment Unit
ALERT	Acute Life Threatening Events Recognition and Treatment
BEACH	Bedside Emergency Assessment Course for Healthcare Assistants
CAP	community acquired pneumonia
CBU	Clinical Business Unit
COPD	chronic obstructive pulmonary disease
CPA	Clinical Pathology Accreditation
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation payment framework
CSW	Clinical Support Worker
CTG	cardiotacography
DNACPR	Do Not Attempt Cardio Pulmonary Resuscitation
ED	Emergency Department
FFT	Friends and Family Test
GI	gastrointestinal
GMC	General Medical Council
GP	General Practitioner
GSTS Pathology	Guy's and St Thomas' Pathology Service
GUM	genitourinary medicine
HEEoE	Health Education East of England
HPA	Health Protection Agency
HSCIC	Health and Social Care Information Centre
HSE	Health and Safety Executive
HSMR	Hospital Standardised Mortality Ratio
ISO	International Organisation for Standardization
MHRA	Medicines and Healthcare Products Regulatory Agency (MHRA)
MINAP	Myocardial Ischaemia National Audit Project
NACR	National Audit for Cardiac Rehab
NASH	National Audit of Seizure Management

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
NHS	National Health Service
NICE	National Institute for Clinical Excellence
NIHR	National Institute for Health Research
NNU	Neonatal Unit
NRLS	National Reporting and Learning System
PACC	Professional Association of Clinical Coders
PALS	Patients' Advice and Liaison Service
PAR	patient at risk
PCNL	percutaneous nephrolithotomy
PLACE	Patient Led Assessment of Care Environments
PRN	*Pro re nata* ('as needed')
PROM	Patient Reported Outcome Measure
QRS	Quality Review Scheme
RAM	risk adjusted mortality
RCA	Root Cause Analysis
RCP	Royal College of Physicians
SBAR	Situation, Background, Assessment, Recommendation
SHMI	Summary Hospital-level Mortality Indicator
TEP	Treatment Escalation Plan
UK CRN	UK Cancer Research Network
VBAC	vaginal birth after caesarean
VTE	venous thromboembolism
WHO	World Health Organisation

Annex 6: Glossary

CHKS	Comparative Health Knowledge System (CHKS) is an independent company that provides health comparison data to hospitals.
Clinical Pathology Accreditation	CPA provides a means to accredit Clinical Pathology Services. It involves an external audit of the ability to provide a service of high quality by declaring a defined standard of practice, which is confirmed by peer review
CQC	The Care Quality Commission (CQC) is the independent regulator of all health and adult social care in England. The aim of the CQC is to make sure better care is provided to people in hospital, in care homes, in their own homes, and elsewhere.
FY1 or FY2	Foundation Year doctors, formerly known as house officers and senior house officers.
HSMR	The Hospital Standardised Mortality Ratio (HSMR) is an indicator of healthcare quality that measures whether the death rate at a hospital is higher or lower than expected.
ISO 15189	International Organisation for Standardization 15189 specifies requirements for quality and competence in medical laboratories. ISO 15189 can be used by medical laboratories in developing their quality management systems and assessing their own competence. It can also be used for confirming or recognizing the competence of medical laboratories by laboratory customers, regulating authorities and accreditation bodies.
NHS Safety Thermometer	The NHS Safety Thermometer is a local improvement tool for measuring and analysing patient harms and harm-free care. It measure four key patient safety issues: pressure ulcers; falls; urinary tract infections; and treatment for venous thromboembolism.
Picker Institute	Picker Institute is a not-for-profit organisation that provides information on patient experience.