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**Bedford Hospital NHS Trust**

**Quality Account 2011**

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## Part 1

### 1.1 Our Commitment to Quality: Statement from the Chief Executive

I am delighted to introduce Bedford Hospital's Quality Account for 2011/12, which sets out the Trust's commitment to providing high quality care. This is our second annual Quality Account.

Quality is at the heart of providing safe, effective care for patients, and a positive hospital experience for patients, relative and carers. At Bedford quality means excellence. It means safe, effective care, dignity, good nutrition, being listened to and heard, being seen on time and being treated with kindness, compassion and respect. We see tens of thousands of patients each year; in planned operations, outpatient appointments and through our emergency department. It is our job to make sure our patients receive quality in all aspects of their care, every time. My view, supported by internal measures and external benchmarking is that quality in the hospital continues to improve.

Making sure we provide quality care depends on a number of things, but vitally, it depends on us listening to what our patients, relatives and carers tell us about the care we provide – what works well and what could be done differently to make their experience better. To this end, we have consulted with patient advocacy groups and other stakeholders in developing this Quality Account and in forming our priorities for improving quality. These views and comments have been incorporated and I am very grateful for their involvement and support.

Through this consultative process, the priorities we have developed for improving quality in care through 2011-12 are:

#### **Patient Safety**

- Prevention of hospital-acquired infection
- Nutrition
- Documentation

#### **Patient Experience**

- Communication about care
- Staff attitude
- Privacy, dignity and respect
- Timeliness of service delivery

#### **Clinical Effectiveness**

- Managing the deteriorating patient
- Improving diabetes care

- Improving dementia care

Our progress in meeting these priorities will be monitored through the Trust's Quality Board and Trust Board.

Thanks to the skill and dedication of our clinical and support staff, I believe we have the drive and commitment necessary to continually improve quality in care at Bedford Hospital, and I look forward to sharing our achievements in next year's Quality Account.

**Joe Harrison**  
**Chief Executive**

## 1.2 Explaining the Quality Account

### What is a Quality Account?

A Quality Account is an annual report to the public about the quality of the services that the hospital delivers. This report has been produced through a process whereby the Board, our directors, leaders of the services and our staff have assessed the quality of the services we deliver and drawn conclusions about what we are doing well and what services need some improvement.

We have reviewed quality from the perspective of its three components:

- Patient Safety
- Patient Experience
- Clinical Effectiveness

### Who has been involved in producing the Quality Account?

The production of this Quality Account drew on sources within the Trust from frontline staff to the Board to identify the services that the Trust delivers well and to review areas where there is room for improvement. Year-round our local stakeholders groups make a continuous contribution to the work of the Trust's committees who oversee quality and safety. In the run-up to the production of this report our local LINKs organisations have been working with us to feed in their local knowledge and the main themes raised with them by service users.

### Key achievements in 2010/11

- Winning the Cleanest Hospital award in the Healthcare Excellence and Leadership (HEAL) awards 2010, as voted for by patients and healthcare workers
- Won the highest level 'Heartbeat' award for healthy food for the 10<sup>th</sup> year in succession
- Performing well in the Care Quality Commission's 2010 National Maternity Survey with 96 per cent of women rating the care they received during their pregnancy as excellent, very good or good
- Achieving BCIS accreditation to commence PCIs
- Achieving a 'good / excellent / excellent' PEAT rating for 2010
- Unconditional CQC registration achieved April 2010
- Being named as a best performing regional stroke unit
- Maternity department shortlisted in the improving maternity services category in the Nursing Times awards
- Achieving a good score regarding patient safety in Dr Foster Hospital Guide 2010
- Achieving good feedback in the Bedford Cancer Services peer review
- Significant reductions in hospital acquired infections
- CHKS 40 Top Hospital award

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## Part 2

### Priorities for Improvement and Statements of Assurance from the Board

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## 2. Priorities for Improvement

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### Introduction

The areas for quality improvement in the coming year reflect the hospital and local community's priorities.

Our approach to identifying the 2011/12 priorities was undertaken in four stages:

1. We engaged with our external partners and in particular the two LINks organisations in our area who have shared the main themes that have been raised with them by users. Bedford LINks members had heard about issues with discharge planning, pressure ulcers, falls, patient meals and communications. Bedfordshire LINks members commented that their concerns were around the visiting policy, the hospital ward at night and patients being moved between wards frequently, nutrition and hydration issues and communication issues internally, between staff and relatives and with patients' GPs, particularly on discharge.
2. Secondly, we reviewed what patients were telling us. We have analysed the themes from complaints and concerns raised with our PALS team and looked into the satisfaction and feedback from our patients and their relatives /carers. They have raised particular individual issues but the main issues throughout the year are concerns about:
  - Communication - within this category the two biggest concerns were communication between staff and lack of information given to them about their care.
  - Aspects of clinical care – the two main concerns were delay in receiving treatment and timely administration of pain relief
  - Attitudes of some staff.
3. We have listened to our staff via a survey on the intranet (internal website for staff) to say what services were good quality and what services needed improvement. Staff concerns included getting the fundamental processes right such as good records and documentation, ensuring staff attended training and were up-to-date and junior doctor cover on the wards, along with particular quality issues for patients such as waiting times in outpatient clinics and delayed discharges.

4. Finally, we have looked at national priorities and drivers namely:

Our Patient Safety strategy includes a programme of regular 'patient safety walkabouts' when our Executives visit wards and departments. Their observations have raised a variety of issues including: oxygen safety, anticoagulation and thrombosis, equipment availability, need for profiling beds, transfer of care and handovers. Our 'Productive Ward' programme continues to provide valuable information regarding ward performance and facilitates identification of areas for improvement and areas of best practice.

Our internal quality committees have looked for any aspects of NICE guidance and national reports which need to be improved locally. They proposed priorities that included: discharge process, nutrition and hydration, communication about care and patient information.

The Trust regularly reviews performance reports such as the East of England QIE Profile report and the CHKS benchmarked data. These sources suggested continued review of mortality data.

As a result of widespread consultation and engagement, all suggested priorities were circulated to the Executive Management Board for a nominative voting process and after consensus voting the Trust has identified the following priorities for improvement in 2011/12:

**Patient Safety**

1. Prevention of hospital-acquired infection
2. Nutrition
3. Documentation

**Patient Experience**

1. Communication about care
2. Staff attitude
3. Privacy, dignity and respect
4. Timeliness of service delivery.

**Clinical Effectiveness**

1. The Deteriorating Patient
2. Diabetes
3. Dementia care

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## 2.1 Patient Safety

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### 2.1.1 Prevention of hospital-acquired infection

#### Description of issue and rationale for prioritising

Whilst we have continued to make excellent progress in controlling and reducing hospital-acquired infections at Bedford Hospital NHS Trust over the past year (see section 3.1.2) this remains a continuing and important priority for us. Our patients and users have also told us that it is an important priority for them.

#### Aim / Goal

- no avoidable hospital acquired infections occur

#### Performance to be measured

- All elective and emergency patients will be screened for MRSA on admission to hospital
- To remain below our ceiling target of hospital acquired MRSA bacteraemia of no more than 2 in 2011/12
- To remain below our ceiling target for C. Difficile infection of no more than 35 in 2011/12

#### Identified areas for improvement

- Implementation of the High Impact Intervention to reduce surgical site infection rate
- Isolation of infected patients (suspected or proven infection) into single rooms when the need is recognised within two hours
- To continue our 24 hour high-clean programme

#### New initiatives to be implemented during 2011/12

- Mandatory monitoring of MSSA bacteraemia
- Development and implementation of MSSA decontamination care bundle

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### 2.1.2 To ensure that our patients have their nutrition and hydration needs met

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#### Description of issue and rationale for prioritising

Patients and public have concerns about eating and drinking whilst in hospital. Bedford Hospital will continue to meet the food and drink needs of all our patients and protect mealtimes. The role of good nutrition in the prevention of pressure ulcers is a linked quality improvement objective.

#### Aim / Goal

- Patients will be nutritionally risk assessed to ensure they are appropriately nourished and hydrated

### **Performance to be measured**

- Patients are weighed on admission to the ward
- All patients are screened for their nutrition risk (MUST Tool)
- Patients identified at risk who require help with feeding will:
  - be identified and have a “red tray” and a red beaker
  - be given the necessary assistance
  - have their ongoing needs re-assessed
- All identified ‘at-risk’ patients will have a 24 hours cumulative fluid balance calculated and nutrition chart maintained.

### **Identified areas for improvement**

- Implement the “Keeping Nourished” care bundle from the *High Impact Actions*.
- Ensure a joined up approach between the care in the hospital and care at home
- Rotate the order in which the wards serve the patients’ meals, last is first next time and the first is last)
- Ensure adequate food choice for all patients including ethnic or religious needs

### **New initiatives to be implemented during 2011/12**

- The prevention and management pathway for nutrition
- Continue to protect mealtimes to ensure the process works for patients, their relatives and carers
- Regular audit programme on wards to check on eating and drinking support
- Matrons and Director of Nursing team members to undertake monitoring ward rounds.
- Exploring the role of volunteers in supporting patients to eat
- Rehydrating people in their own home to prevent unnecessary hospital admissions (in partnership with the community service provider)
- Working with the care sector to enhance nutritional care for clients with a learning disability (LD) requiring acute hospital care

## **2.1.3 Improve care by better documentation in the patient’s records**

### **Description of issue and rationale for prioritising**

Good record keeping is an integral part of healthcare practice and is essential to the provision of safe and effective patient care. It is the mark of a skilled practitioner. The principles of good record keeping apply to all types of records, regardless of how they are held and our staff recognise the

risk presented by incomplete and poor documentation. Staff are aware that they have a duty to communicate fully and effectively with patients, relatives and colleagues, ensuring that they have all the information they need about the people in their care. Nevertheless, improvements can be made in how we do this.

### **Aim / Goal**

- To promote high standards of documentation through a standardised, systematic and planned approach to records
- To meet the expected standards for record keeping
- To ensure all staff recognise their own responsibility for keeping good records standards

### **Performance to be measured**

- Compliance with record keeping standards by all healthcare professionals
- Evidence of planning and evaluation of care in partnership with patients / carers

### **Identified areas for improvement**

- Standardisation of patient records
- Ongoing education and training in relation to documentation
- Evaluation of records to monitor quality
- Reference to the single assessment paperwork should be made to ensure that discharge planning reflects the patient's personal (at home) situation

### **New initiatives to be implemented during 2011/12**

- Plan the implementation of Electronic Patient Records (EPR)
- Common format for all ward areas
- Unified risk assessment document
- Director of Nursing, Medical Director and Matron's ward rounds

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## **2.2 Patient Experience**

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### **2.2.1 To improve communication by providing clear information to patients**

#### **Description of issue and rationale for prioritising**

The need for improved availability and use of patient information has been raised by our LINKs colleagues and inpatient feedback. This is supported by the low response in the national inpatient survey to the questions about information about their treatment

### **Aim / Goal**

- To improve the availability of information for patients in verbal, written and electronic format from our website and meet the needs of patients with communication difficulties

### **Performance to be measured**

- Improved satisfaction responses to patient survey questions

### **Identified areas for improvement**

- Continue with improving attitudes and behaviours towards patients through customer care training
- Raise awareness amongst staff of the patient information available in order for them to signpost patients and carers
- Improved availability of patient information via the hospital website
- Improve information available to meet the needs of vulnerable groups
- Enable patients to have access to and be able to input to their care plan and records
- Clinical staff will improve the processes for listening to patients concerns.

### **New initiatives to be implemented during 2011/12**

- Dementia / Older Person forum
- Continue the Learning Disability forum
- Roll out specific information work streams e.g. reducing pressure ulcers, dementia care etc

## **2.2.2 Staff attitude: to ensure patients have their concerns addressed**

### **Description of issue and rationale for prioritising**

There have been instances reported to us when patients have perceived they have interacted with a member of staff who displayed a 'bad attitude'. There will always be a high intensity of clinical workload so this should be managed. Other causes can be poor communication style and lack of self awareness of how a brusque attitude can come across to both patients and staff

### **Aim / Goal**

Bedford Hospital NHS Trust's workforce strategy has five key strands that are all about the increased participation of staff:

- Developing new ways of working
- Having a high performing workforce
- Being an employer of choice

- Creating a positive culture
- Improving and increasing staff engagement

A customer service and values training programme, 'Personal Best' was introduced in 2010. As a Trust we are now looking at customising an ongoing training programme to meet the local needs of this hospital. We aim to ensure that during 2011/2012 every member of staff attends and embraces this training and its ethos

### **Performance to be measured**

- To reduce the number of complaints that cite the main reason to be staff attitude
- Patients perceive good working relationships amongst the clinical team
- Patients perceive the wards as a warm, positive and friendly place to be

### **Identified areas for improvement**

Through the development of a Trust Organisational Development Strategy there will be a drive to deliver organisation development programme designed to engage staff and create a culture where the patients' needs take priority and where positive behaviours are promoted through our values and behaviours framework, the following are key strands of this work:

- Developing a culture of accountability and ownership, underpinned with consistent firm and fair management practices
- Fully engaging the workforce to drive change through new ways of working, continuous improvement and living our values
- Creating a shared purpose, connecting the Trust's purpose with that of the workforce
- Promoting staff involvement in decision making at all levels of the Trust
- Conversations between staff in front of patients should take place in English

### **New initiatives to be implemented during 2011/12**

- Customer care will become part of the Trust's Values Framework; it will be re-launched in 2011 with a new name.

An overview of what we aim to achieve through this is:

During the past year, the 'Personal Best' programme enabled staff to identify what good quality customer care meant to us and helped create and reinforce excellent standards and values in customer care for staff and patients alike. The ultimate aim being to encourage patients to choose our services based on their positive experiences and the positive experiences of their friends and families, in relation to the service delivered to them. Through a further programme of Action Learning Workshops being delivered through team meetings/team training/team away-day events through 2011 and beyond, all Trust staff will be involved in looking how to remove possible

obstacles and reinvigorating attitudes to care and compassion, we open the way for team members at all levels to experience the pride of giving the best care experience every day and with every patient, every relative/visitor and every colleague.

By getting back to the fundamentals of excellence in communication, we will use the ABC approach of last year's programme in every interaction we have and look at ways of doing so despite the pressures we often face within our own work areas. Other desired outcomes of our continued approach to excellence in customer care includes:

- improving the patient/visitor experience
- improving staff motivation and morale – with a greater focus on patients,
- improving management focus on the way in which staff are being and interacting with patients, visitors and colleagues
- improving outcomes in other initiatives such as Productive Ward

With patients, visitors and staff feeling increasingly valued and respected Bedford Hospital NHS Trust will go forward into the new NHS era as a valued asset to its community.

### 2.2.3 To improve patient experience through respect for privacy and dignity

#### Description of issue and rationale for prioritising

Patients need to be cared for in an environment that is clean and comfortable but also with the support of staff who protect their dignity in the everyday ward or outpatient clinics and whilst undergoing sensitive interventions and treatment.

This is particularly important for elderly patients, where anecdotal evidence from recent national reports has indicated that maintaining their dignity and treating them with respect has not always happened when they have been in hospital. This Trust supports the principles and values embodied in the Dignity in Care Charter.

#### Aim / Goal

- Every patient is treated with dignity and respect

#### Performance to be measured

- All patients will be accommodated in single sex accommodation
- All patients report a positive feedback on their satisfaction with protecting their privacy and dignity in our local and national surveys
- Increase on positive response to recommending Bedford Hospital
- Use the *Essence of Care* benchmarking materials and ensure that the requirements of the CQC *Essential Standards* Outcome 1 are met

- Staff are proactive in maintaining privacy and dignity

#### **Identified areas for improvement**

- Staff awareness of patients who lack mental capacity and best practice in maintaining privacy, dignity and modesty
- Modesty is achieved for patients moving between wards and departments
- Better bed curtains with curtain clips and “Do not enter” signs on doors
- Appropriate clothing / better hospital gowns
- Improve the endoscopy department for compliance with single sex accommodation by introduction of single sex procedure lists
- Improved facilities for Learning Disability patients and those with special needs
- Workshops on privacy and dignity issues
- Personal information not being discussed in public

#### **New initiatives to be implemented during 2011/12**

- Support the Dignity in Care charter by ensuring an increase the number of Dignity Champions by achieving one in every ward
- Privacy and Dignity is a core theme delivered through the training and education programme
- Participate in Dignity in Action days
- Matron and Director of Nursing ward rounds

### **2.2.4 Timeliness of service delivery: to improve our patients’ experience by the reduction of the time spent waiting in outpatients clinics and prior to discharge from hospital**

#### **Description of issue and rationale for prioritising**

Timeliness of service delivery is a key component of quality. Our patients have an expectation that they will be seen in the outpatient clinics within a reasonable time of their appointment (the standard of being seen within 30 minutes was established in the Patients Charter). Our patient’s response to the national outpatients survey and the feedback from our local community has indicated that this is a quality issue for us to improve. Similarly an improvement is called for in the reduction in the waiting time between the decision to discharge a patient from hospital to their paperwork and medications being ready for them to go home.

#### **Aim / Goal**

- Our patients will be seen in outpatient clinic at the appointed time
- To reduce the time patients spend waiting for discharge

### **Performance to be measured**

- Outpatients: Patients will be seen in outpatient clinics within 30 minutes of their appointment time
- Discharge planning measurement: Decision to discharge and discharge plan has been developed within 24 hours of the patient's admission

### **Identified areas for improvement**

Outpatients:

- Reduction of overbooking and appointments review of patients per booking slot
- Escalation process when delay occurs
- Use television screens to inform patients about waiting time for each clinic
- Nurses to notify patients when there is a delay in clinics
- Receptionist to inform patients about waiting times on arrival

Discharge process:

- Use of estimated date of discharge as part of the patient pathway
- Medication on admission is documented accurately
- Paperwork is maintained up-to-date during the patient's stay
- TTO (To Take Out medication) is ready the day before discharge
- Pharmacy record when they receive the TTO prescription
- Pharmacy continue inconsistency checks and feedback to clinical teams

### **New initiatives to be implemented during 2011/12**

- Discharge – 'Home for lunch' project

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## **2.3 Clinical Effectiveness**

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### **2.3.1 Identifying and responding to the needs of the acutely ill deteriorating patient**

#### **Description of issue and rationale for prioritising**

National reports have identified that some patients who are, or become, acutely unwell in hospital may receive poor care that does not meet their clinical needs because their deterioration is not recognised, not appreciated or not acted upon sufficiently quickly. At Bedford Hospital significant improvements have already been implemented such starting the Critical Care Outreach service to wards and improved assessment of Patients At Risk (PAR) on the wards.

### **Aim / Goal**

- To continue the reduction in avoidable hospital deaths and cardiac arrests through improved standard of observations, fluid management, communication and reducing the risk of further deterioration

### **Performance to be measured**

- Observations are taken in line with best practice
- Early signs of deterioration are recognised using a Patient At Risk (PAR) score
- Patients that are considered at risk receive appropriate early review
- Fluid balance monitoring is accurate
- Critical medicines are administered on time
- Continued participation in the National Cardiac Arrest Audit (NCAA) 2010-2013

### **Identified areas for improvement**

- Continue to improve the documentation of observations
- Further training of all staff who undertake and record patient observations to ensure they are competent to recognise the acutely ill deteriorating patient

### **New initiatives to be implemented during 2011/12**

- Expansion of the 12 hour PAR team to cover 24 hours
- Implementation of the Intelligent Fluid Management Care Bundle
- Roll out of the 'SBAR' communication tool

## **2.3.2 Control of inpatients' diabetes-prevention of hypoglycaemia**

### **Description of issue and rationale for prioritising**

Approximately 20% of patients admitted to Bedford Hospital have diabetes in addition to their reason for admission. These patients can be cared for in any ward therefore we believe it is important that they get the right care for their diabetes wherever they are cared for. This approach is supported by the 'Think Glucose' national campaign which aims to ensure all diabetic patients receive the right care at the right time in the right place given by the right person.

### **Aim / Goal**

- To work towards achieving the 'Think Glucose' aims by the prevention of recurrent hypoglycaemia.

### **Performance to be measured**

- All hypoglycaemic episodes will be treated appropriately
- Medication review takes place in a timely way
- Regular audits including patient satisfaction with how their treatment of their diabetes was managed
- Reduction of the risk of recurrent hypoglycaemia
- By participation in the National Adult Diabetes Audit

### **Identified areas for improvement**

- Daily management of patients with diabetes in addition to their admission illness
- To implement a monthly audit of all patients with diabetes on all wards
- To improve communication between the ward, medical and nursing teams and the specialist diabetic team

### **New initiatives to be implemented during 2011/12**

- To achieve the CQUIN in relation to diabetes care developed for 2011/12
- To implement the diabetes e-learning tool for all new clinical staff and all permanent qualified nursing staff to undertake
- Regular teaching module on clinical updates for permanent medical staff

### **2.3.3 Dementia care: to ensure development and implementation of the care pathway for dementia patients within the acute Trust which dovetails with the county wide dementia pathway**

#### **Description of issue and rationale for prioritising**

As the elderly population grows there are more patients being admitted to Bedford Hospital for acute care who may also have dementia. In the acute hospital setting we have identified that the length of stay for patients with dementia is longer than for patients with similar medical illness without dementia. Bedford Hospital is keen to work with local community to meet this growing need.

#### **Aim / Goal**

- To ensure the needs of people with dementia in acute care are met
- To implement the national plan

#### **Performance to be measured**

- Benchmarking against the dementia strategy

#### **Identified areas for improvement**

- To carry out a gap analysis of the trusts services against National standards
- Early identification of dementia patients and the inpatient management of their conditions
- Take a partnership approach to meet dementia patients needs
- To improve the quality of care by having a clear and standardised patient pathway
- Discharge planning support
- Develop champion wards (two Medical wards and one orthopaedic) identified as improvement areas. Each of these improvement areas will have a plan for achievement and there will be an identified named sponsor and lead for each area
- Our staff achieve improved awareness through training in the care of patients with dementia

#### **New initiatives to be implemented during 2011/12**

- Achieve Dementia CQUIN
- Continue taking part in National Audit for Dementia
- To implement the 'This is me' Care Bundle
- Improved volunteer involvement on wards

This will build on the good practice already in place in Bedford Hospital for acutely ill patients with Learning Disabilities.

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## 2.4 Statement of Assurance

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The statements in the following section in *italic text* is mandatory text that all NHS Trusts must include in their Quality Account.

### 2.4.1 Review of services

*During 2010/11 Bedford Hospital NHS Trust provided Acute NHS services (See Appendix 1). The Trust has reviewed all data available to them on the quality of care in all of these NHS services. The income generated by the NHS services reviewed in 2010/11 represents 100% of the total income generated from the provision of NHS services by the Bedford Hospital NHS Trust for 2010/11.*

The safety, effectiveness and patient experience of all our clinical services is monitored on a monthly basis through a process of divisional review. Information considered as part of this review includes results from the monthly patient experience audits, outcomes from complaints and untoward incidents. This information is reported on a monthly basis to the Quality Performance Committee (now Quality Board) and the Executive Management Team. Quality information is presented to the Board via a performance scorecard format and includes separate reports on Patient Safety, Patient Experience and Clinical Effectiveness.

**Patient Safety** data is sourced from our internal information on incident reporting, patient harm events, falls and medication errors. Data is analysed and benchmarked against NPSA data. Appropriate action plans are implemented where necessary. Hospital acquired pressure ulcer and VTE monitoring results are also reported to our Board monthly.

**Patient Experience** data is sourced from our internal surveys of patient satisfaction and analysis of complaints, concerns and compliments. Executive team 'walkabouts' and Modern Matron/Senior Nurse 'ward rounds' are also useful sources of qualitative information.

**Clinical Effectiveness** data is provided by our use of the CHKS Signpost benchmarking information and our internal clinical audit reports. Trust performance compared to clinical standards has been reviewed by our participation in national audits – (see the following section) such as those for stroke, cardiac arrest and vascular services.

In addition the Trust reviews regular quality reports from **Quality Intelligence East (QIE)** which are triangulated with both internal metrics and those generated through CHKS which provide regular and more immediate data. HSMR is currently monitored by the analysis of QIE information until the introduction of the national comparative measure for mortality.

Quality and governance data is also submitted on a monthly basis to NHS East of England this data is based on the Monitor Governance balanced scorecard. The Trust's Quality Plans are the Quality Account priorities and the Quality Innovation and Productivity Plan (QIPP) which applies LEAN principles and sets out its rolling quality improvement plan. This plan is regularly reviewed by the Trust Board.

## 2.4.2 Participation in clinical audits:

During 2010/11 42 national clinical audits and 5 national confidential enquiries covered NHS services that Bedford Hospital NHS trust provides.

During 2010/11 Bedford Hospital NHS Trust participated in 71% of national clinical audits and 100% 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 2010/11 are as follows:

**Table 1: List of national clinical audits this Trust was eligible to participate in**

National Audit	Bedford Hospital participation	Cases submitted or reason for not participating
<b>Peri- and Neonatal</b>		
Perinatal mortality (CEMACH)	✓	21 cases submitted (100%)
Neonatal intensive and special care (NNAP)	✓	All cases to be submitted (100%)
<b>Children</b>		
Paediatric pneumonia (British Thoracic Society)	✗	Not undertaken in 2010-11
Paediatric asthma (British Thoracic Society)	✗	Not undertaken in 2010-11
Paediatric fever (College of Emergency Medicine)	✓	58/50 (100%) submitted
Childhood epilepsy (RCPH National Childhood Epilepsy Audit)	✓	Data collection underway Feb '11 – Aug '11
Diabetes (RCPH National Paediatric Diabetes Audit)	✓	(100%) All relevant cases submitted
<b>Acute care</b>		
Emergency use of oxygen (British Thoracic Society)	✗	Local audit undertaken
Adult community acquired pneumonia (British Thoracic Society)	✗	Local audit undertaken
Non invasive ventilation (NIV) - adults (British Thoracic Society)	✗	Local audit undertaken
Pleural procedures (British Thoracic Society)	✗	Local audit undertaken
Cardiac arrest (National Cardiac Arrest Audit)	✓	1/1 (100% that met the criteria)
Vital signs in majors (College of Emergency Medicine)	✓	50/50 (100%)
Adult critical care (Case Mix Programme)	✓	(100%) All cases to be submitted
Potential donor audit (NHS Blood & Transplant)	✓	68 cases submitted
<b>Long term conditions</b>		
Diabetes (National Adult Diabetes Audit)	✓	56/56 (100%)
Heavy menstrual bleeding (RCOG National Audit of HMB)	✓	4 year plan- data collection started
Chronic pain (National Pain Audit)	n/a	Service not provided, now run by Horizon health
Ulcerative colitis & Crohn's disease (National IBD Audit)	✓	40/40 (100%) cases submitted
Parkinson's disease (National Parkinson's Audit)	✗	Trust not invited to participate
COPD (British Thoracic Society/European Audit)	✓	Data collection underway
Adult asthma (British Thoracic Society)	✗	Local audit undertaken
Bronchiectasis (British Thoracic Society)	✗	Local audit undertaken

### Elective procedures

Hip, knee and ankle replacements (National Joint Registry)	✓	249/279 (100% of patients who have consented to be registered)
Elective surgery (National PROMs Programme)	✓	Response rate 69.8% (National: 69.7%)
Coronary angioplasty (NICOR Adult cardiac interventions audit)	✓	Mar '11 – data collection underway
Peripheral vascular surgery (National Vascular Database)	✓	104 cases
Carotid interventions (Carotid Intervention Audit)	✓	26/29 (89%)
<b>Cardiovascular disease</b>		
Familial hypercholesterolaemia (National Clinical Audit of Mgt of FH)	✓	Organisational audit. (No clinical information submitted)
Acute Myocardial Infarction & other ACS (MINAP)	✓	100% all eligible cases -Ongoing
Heart failure (Heart Failure Audit)	✓	223/230 (97%)
Pulmonary hypertension (Pulmonary Hypertension Audit)	✗	Not undertaken in 2010-11
Acute stroke (SINAP)	✗	Herts and Beds Stroke and Heart Network to participate in later cycles.
Stroke care (National Sentinel Stroke Audit)	✓	60/60 (100%)
<b>Renal Disease</b>		
Renal Colic	✓	26/50 submitted so far-ongoing
<b>Cancer</b>		
Lung cancer (National Lung Cancer Audit)	✓	20 cases so far , ongoing next upload June 2001 expected total 86
Bowel cancer (National Bowel Cancer Audit Programme)	✓	148 submitted to date, ongoing
Head & neck cancer (DAHNO)	✓	Data submitted via Luton and Dunstable Hospital.
<b>Trauma</b>		
Hip fracture (National Hip Fracture Database)	✓	138/138 (100%)
Severe trauma (Trauma Audit & Research Network)	✓	164/164 (100%)
Falls and non-hip fractures (National Falls & Bone Health Audit)	✓	Group 1: 38/40 Group 2: 20/20
<b>Blood transfusion</b>		
O neg blood use (National Comparative Audit of Blood Transfusion)	✓	16/16 (100%)
Platelet use (National Comparative Audit of Blood Transfusion)	✗	No substantive Consultant Haematologist in post.

*The national clinical audits and national confidential enquiries that Bedford Hospital NHS Trust participated in and for which data collection was completed during 2010/11 are listed (see Table 1) 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 the audit or enquiry.*

**Table 2: Participation in national confidential enquiries**

i.	<i>The number of confidential enquiries in which we could have participated in 2010/11</i>	5
ii.	<i>The number if which we did participate</i>	5
iii.	<i>The names of the enquiries in which we participated</i>	1. Parenteral Nutrition “ A mixed bag” 2. Emergency Surgery in the Elderly “An Age Old Problem” 3. Peri-operative care (underway) 4. Surgery in children (underway) 5. Cardiac arrest procedures(underway)
iv.	<i>The number of cases for which data collection was completed and submitted to each audit as a percentage of the number required by the terms of the enquiry</i>	1. 9/9 (100%) 2. 9/9 (100%) 3. 6/6 (100%) Peri-operative care – data collection still underway 4. data collection underway

		5. data collection underway
v.	<i>The number of national clinical audit reports that were reviewed by the provider during the reporting period</i>	72

*The reports of four national clinical audits were reviewed by the provider in 2010/11 and Bedford Hospital NHS Trust intends to take the following actions to improve the quality of healthcare provided:*

<b>National Audit reports published in 2010</b>	<b>Bedford Hospital Action</b>
Perinatal Mortality (CEMACE)	The Trust stillbirth and early neonatal death rates were low and both were below the national average. These have been noted. <ul style="list-style-type: none"> <li>• National stillbirth rate: 4.7 per 1,000 live births</li> <li>• Local stillbirth rate: 3.1 per 1,000 live births</li> <li>• National neonatal death rate: 2.8 per 1,000 live births</li> <li>• Local neonatal death rate: 0.3 per 1,000 live births</li> </ul> The Trust does not need an action plan as there is no action necessary at this point. We will continue to monitor our performance to ensure maintenance of good practice
National Audit of the Management of Familial Hypercholesterolaemia 2010	We noted that our performance is in line with other similar providers but the service is not identified by our Commissioners for further development by this Trust
National Audit of continence care	This trust will develop a continence assessment procedure and improve staff awareness of continence care through training in its use
National Dementia Audit	A Dementia strategy is under development and a forum has been established to oversee the action. This is a priority area in this Quality Account

*The reports of 72 local clinical audits were reviewed by the provider in 2010/11 and the Trust intends to take the following actions to improve the quality of healthcare provided :*

<b>Local Audits</b>	<b>Action to improve quality</b>
Venous Thromboembolism Compliance with NICE CG	We have introduced an electronic risk assessment process with the aim that all patients admitted to hospital are assessed and the appropriate prophylaxis treatment or medication is given
Blood cultures	We have provided training to raise staff awareness of best practice and the development of improved skills in the taking of blood cultures to avoid the risk of sample contamination
Blood transfusion	We have rolled out Competency assessment and training for staff in blood transfusion skills
WHO (World Health Organisation) Pre operative Checklist	We have implemented the checklist across the Trust and are seen as an exemplar site. We have localised the checklist with additional check items added. We have further instigated of a pre-meeting before theatre sessions to improve communication across all clinical staff groups involved in theatres
NICE CG 99 Constipation in children	We have improved information for parents
NICE CG 84 Diarrhoea and Vomiting	We have developed Information sheets for parents and new trust guidelines written and implemented

Pharmacy	We have established a multidisciplinary Action Group to improve discharge prescribing with leads identified from each clinical division
Discharge letters	Improvements have been made by junior doctors on the completeness of all the parts of the content of the letters, including better reporting of the follow up arrangements, more accurate allocation of the patient's Consultant and passing on better information on what has been discussed with the patient

### 2.4.3 Participation in clinical research:

*The number of patients receiving NHS services provided by the Trust in 2010/11 that were recruited during that period to participate in research approved by a research ethics committee was 690 .*

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

*The Trust was involved in conducting 76 clinical research studies. 26 clinical staff participated in research from 8 medical specialties. The Trust completed 10% of these studies as designed within the agreed time and to the agreed recruitment target. The Trust used national systems to manage the studies in proportion to risk. Of the 76 studies given permission to start, 100% were given permission by an authorised person less than 30 days from receipt of a valid complete application. 100% of the studies were established and managed under national model agreements and 20% of the 76 eligible research involved used a Research Passport. In 2010/11 the National Institute for Health Research supported 54 of these studies through its research networks.*

*In the last three years, 140 publications have resulted from our involvement in NIHR research, helping to improve patient outcomes and experience across the NHS.*

### 2.4.4 Goals agreed with commissioners

- **Use of CQUIN payment framework**

*A proportion of Bedford Hospital NHS trust's income in 2010/11 was conditional on achieving quality improvement and innovation goals agreed between the trust and NHS Bedfordshire.*

*Further details of the agreed goals for 2010/11 and the following 12 month period are available electronically at [www.bedfordhospital.nhs.uk](http://www.bedfordhospital.nhs.uk)*

#### **CQUINs 2010/11**

The goals were agreed with the commissioner for 2010/11 against the three domains of quality: safety, effectiveness and experience and an additional domain innovation. These areas also deliver regional pledges for improvements.

<b>CQUINs 2010-11</b>
<b>Safety</b>
Reduce mortality rate (SMR)
Reduce Unadjusted Mortality Rate
National Venous Thromboembolism (VTE) Risk assessment
Reduce number of Stroke patients who are discharged to nursing or residential care from stroke unit
<b>Patient Experience</b>
achievement of 97% “net promoter” score
achievement of 100% of patients who rate their care Very Good or Excellent
Achieve composite indicator on responsiveness to personal needs (Inpatient survey)
evidence that staff have been trained in advance care planning
Partnership working to enable patients to die in place of their choice
<b>Clinical Effectiveness</b>
Reduce wait for brain imaging to confirm stroke diagnosis
Increase number of patients with ischaemic stroke who receive thrombolysis
Increase number of patients with primary diagnosis of stroke cared for on specialized ward
Reduce prevalence of smoking at delivery
Increase initiation of breastfeeding
Participation in TARN
Participation in national hip Fracture database
Increase patient outcomes based on trauma audit outcomes
Global trigger toll used to effect change
<b>Innovation</b>
Dementia care plan
Implementation of dementia pathway
Patient and carer satisfaction with discharge process
Improve patient and carer satisfaction with discharge process and outcome
Help patients stop smoking
Patient satisfied with the support to stop smoking

(At the time of publishing the report, the outcome was not finalised. This will be added to the published version of this Quality Account once achievement is confirmed)

#### 2.4.5 What others say about Bedford Hospital NHS Trust

- **Statements from the CQC**

*Bedford Hospital NHS trust is required to register with the Care Quality Commission and its current registration status is unconditional, as at 31 March 2011. The Care Quality Commission has not taken enforcement action against Bedford Hospital NHS Trust during 2010/11.*

*Bedford Hospital NHS Trust is not subject to periodic reviews by the CQC as at 31<sup>st</sup> March 2011.*

*Bedford Hospital NHS Trust has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2010/11:*

- *CQC Unannounced visit to review A&E staffing over Christmas and New Year as part of a national programme.*

The final report was not available on the 31<sup>st</sup> of March 2011.

- **Data quality (statements on relevance of data quality and actions to improve data quality)**

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

- Internal data quality group now in place – chaired by a doctor
- ‘Top ten’ data quality problems identified for improvement in 2011-12
- Review of critical datasets to improve coverage & validity
- **NHS number and general medical practice code validity**

*Bedford Hospital NHS trust submitted records during 2010/11 to the Secondary Uses service for inclusion in the Hospital Episode statistics which are included in the latest published data which included the patient’s valid NHS number was:*

*99.8% for admitted care  
99.2% for outpatient care  
88.3% for accident and emergency care*

*which included the patient’s valid general medical practice code was:*

*99.9% for admitted patient care  
99.8% for outpatient care  
99.7% for accident and emergency care*

- **Information governance toolkit attainment levels**

*Bedford Hospital NHS Trust Information Governance Assessment Report score for 2010/11 for Information Quality and Records Management assessed using the Information Governance Toolkit was 63% and was graded red.*

The Trust has developed a staff IG training programme to improve this rating.

- **Clinical coding error rate**

*Bedford Hospital NHS Trust was not subject to the payment by results clinical coding audit during 2010-11 by the Audit Commission.*

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## Part 3

### Looking back – How we performed on Quality in 2010/11

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

#### **Patient Safety**

- i. To have no hospital-acquired venous thromboembolism.
- ii. To have no avoidable hospital-acquired *c. difficile* infection
- iii. To improve the Hospital Mortality Rate (HMR) year on year

#### **Clinical Effectiveness**

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

#### **Patient Experience**

- i. To implement the Trust Patient Experience Strategy
- ii. To improve the patient rating of overall care and experience (in the national survey)
- iii. To improve the care of the dying patient

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## 3.1. Patient Safety

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### 3.1.1 To have no avoidable hospital-acquired venous thromboembolism (VTE)

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We are committed to ensuring that our patients are assessed for the risk of venous thromboembolism and given prophylaxis if they need it.

#### **Goals**

- No avoidable hospital-acquired venous thromboembolism during the year.
- To ensure that all patients admitted to hospital are assessed for the risk of thrombosis and bleeding on admission in accordance with the national risk-assessment process.
- To ensure that all appropriate patients receive chemical prophylaxis, mechanical prophylaxis, early mobilisation or a combination of all three.

#### **Outcome 2010/11 measured performance**

The VTE Steering Committee has met regularly throughout the year and overseen the project work to establish a computerised risk assessment tool.

By August 2010 the risks assessment process was in place and the number of patients that were assessed for VTE risk had increased from the 6.2% recorded in 2009 to 97.2% in March 2011.

An audit of patients in December 2010 found that 70% had been given appropriate medication for the prevention of VTE, an improvement from the 57% reported in 2009.

An audit of the management of patients who have been diagnosed with a venous thromboembolism is underway but has not yet been reported. Once completed, the learning will be shared across the organisation.

#### **Action taken to avoid hospital-acquired venous thromboembolism:**

- The introduction of an electronic risk assessment tool, revised admission documentation and drug prescription charts to support VTE risk assessment
- A publicity campaign to inform all patients and staff of the implications of VTE was included in our Patient Safety open day on 16 October 2010
- We revised our policy to comply with the new Department of Health and NICE recommendations
- The Trustwide audit of compliance with best practice was presented to our clinical teams at their clinical audit sessions in January 2011
- Risk assessment compliance figures are reported monthly to the Trust Board

The Trust supports the QIPP NHS Safer Care agenda and takes part in quarterly 'safety thermometers'. This is a national data collection exercise involving 100 organisations to systematically examine VTE risk assessment documentation, appropriateness of prophylaxis and the treatment of diagnosed VTEs on a given day in March, June, September and December

### **3.1.2 To have no hospital-acquired *Clostridium difficile* infections**

We achieved a 60% reduction in *C.difficile* cases compared to the previous year. Patients continue to acquire *Clostridium difficile* infection in hospital even though the number is reducing. This infection may sometimes cause severe problems for patients and in 10% of cases may cause death.

#### **Goal**

Our goal was to reduce the number of patients who acquire *Clostridium difficile* as a result of inpatient care at this hospital.

#### **Outcome 2010/11- measured performance**

On the 31<sup>st</sup> of March 2011, this Trust had been 52 days since the last case of *C.difficile* and 267 days since the last MRSA bacteraemia.

#### **Available isolation rooms**

#### **Achieved 2010/11**

The Trust has continued to ensure that a cohort (ward specifically for patients with infection) is available when needed and has 44 single rooms

in non-specialist, adult areas. A plan is in place to improve isolation times

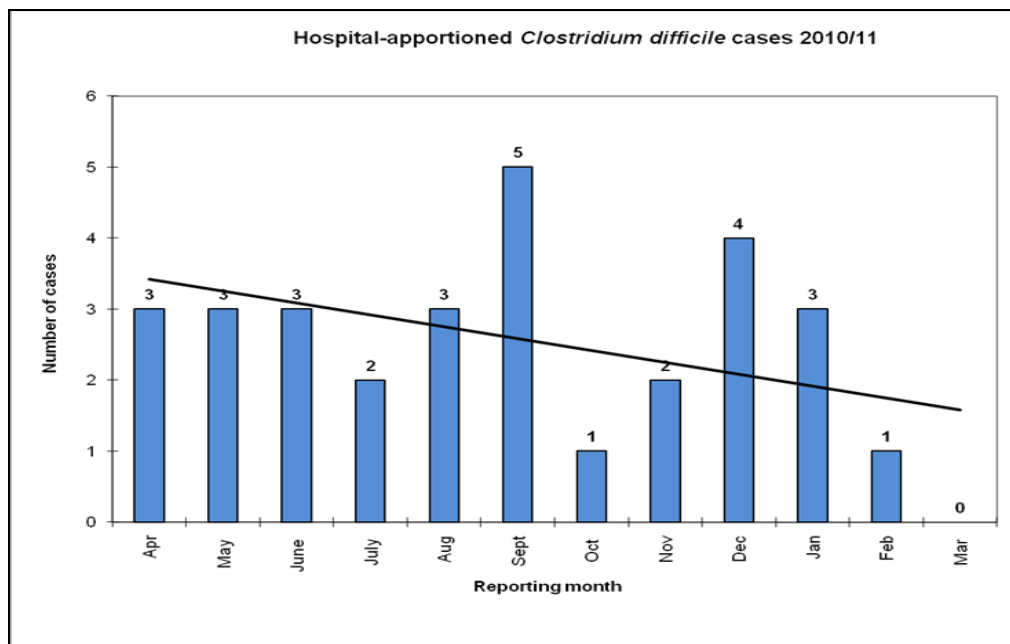
**Patients requiring isolation for *C. difficile* are allocated an isolation bed within 2 hours of results**

We achieved 67% (20/30). For the 10 patients outside of this target, 7 were isolated within 4 hours and 1 within 6 hours, 2 patients were discharged with appropriate advice. High bed occupancy and hospital activity was the cause for delay.

**Hospital – acquired *C. difficile* infection**

At the end of March 2011 the Trust was at 30 cases against a ceiling of 56 cases. The SHA target for 2010/11 was less 25% i.e. <56 infections

**2010/11 *C. Difficile***



**Action taken to reduce *C.difficile* infection**

- Introduction of sporacidal cleaner
- Promotion of hand hygiene
- Dedicated isolation unit with expert medical, nursing and support services staff
- Staff identifying and isolating cases very promptly
- Antibiotic stewardship by pharmacists and monthly audit

**3.1.3 To improve the Hospital Mortality Rate (HMR)**

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

## Goal

To reduce mortality rate by 2% on 2009/10 baseline. CHKS risk adjusted data has been used until another nationally agreed measure is identified. Hospital Standardised Mortality ratios (HSMR) are another measure of mortality, available through Dr Foster Limited. This takes a slightly different statistical view of mortality to risk adjusted.

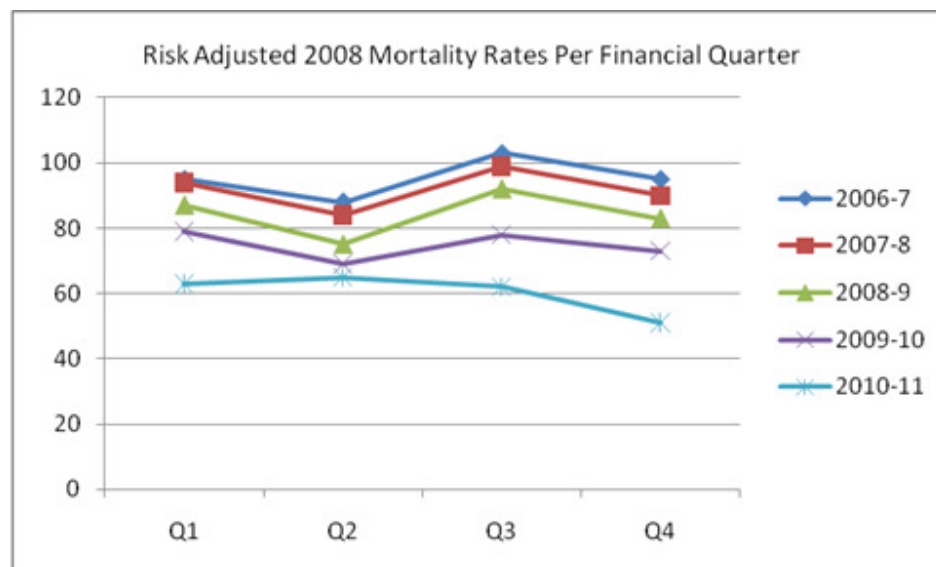
## Outcome 2010/11 - measured Performance

	2009/10	2010/11	
Risk adjusted mortality rate (RAMI)	87	68	Achieved

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

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

## Progress



The Quality Intelligence East (QIE) profile gives the Trust's HSMR based on 2008/09 data as for 2010/11 up to Q3 as 97. This is a different measure to RAMI and the Trust is within expected limits (most recent available at time of publication).

- The Patient at Risk team (PAR) continued in 2010/11, visiting the very sickest of patients on wards, preventing unnecessary admission to critical care
- Use of the Global Trigger Tool (GTT) has helped identify where care and treatment could be improved to promote patient safety

### Action taken to reduced mortality during 2010/11

- The Patient At Risk team (PAR) hours were extended to provide continuous cover seven days a week from 08.00 to 20.00hrs
- Specialties undertook regular review of their patient deaths to assure the data quality and identify any learning and aspects of care for improvement

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## 3.2 Clinical Effectiveness

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### 3.2.1 To improve care for stroke patients

Stroke Services at Bedford Hospital have continued to improve over the past financial year with developments that have included the establishment of a daily TIA (transient ischaemic attack) clinic, hyper acute facilities in the stroke unit and the introduction of joint-care plans (NHS and social services) for all stroke patients discharged from Bedford Hospital.

The Victoria Stroke Unit has become one of the best performing units in the East of England. The National Stroke Sentinel Audit results for 2010, made public in May 2011, places Bedford Hospital firmly in the upper quartile for the 12 key indicators which means that the stroke unit is in the top 25% of stroke units in the country. Our results emphasise great improvements in multidisciplinary assessment, care planning and acute care.

There is still more work to do and stroke remains one of our core priorities.

#### Goal

- To reduce the time to wait for brain imaging to confirm ischaemic stroke
- To increase the number of patients with ischaemic stroke who receive thrombolysis
- To reduce the number of patients who are newly institutionalised after a hospital episode for stroke

#### Outcome 2010/11 - measured performance

Bedford Hospital has received a letter of commendation from the Regional Medical Director for being the most improved stroke unit as measured by the National Stroke Audit.

	Achieved 2010/11			
	Q1	Q2	Q3	Q4
Patients with a stroke are cared for the specialized ward for 95% or more of their stay.	75%	76%	67%	82%

Brain imaging to confirm ischaemic stroke is undertaken within 24 hours of admission	77%	85%	79%	90%	An improvement from 47% to 91% has been achieved. Access to urgent scanning for patients who could be potentially thrombolised is 100%
All patients who have confirmed ischaemic stroke and meet the inclusion criteria are offered thrombolysis	7.14% (15/210)				We have increased the rate from 2% last year. further service improvements have been made to extend our 9-5 service by an out-of-hours service from the Luton and Dunstable Hospital
Patients discharged to NHS institutional care. (We aim to discharge patient back to the same residence on admission)	8.2% (19/231)				The discharge to institutional care for stroke patients at Bedford Hospital is one of the lowest in the country. Our % for the patients included in the 2010 Sentinel Audit was only 2% compared to a national median of 10%. This year, so far, we have discharged only 19 patients to either a residential or nursing home.

### Action taken to improve stroke care in 2010/11

- Reduction in time to wait for brain imaging to confirm ischaemic strokes
- Increase in thrombolysis
- Decrease in discharges to institutional care

### 3.2.2 To have no hospital-acquired pressure ulcers

Pressure ulcers are a significant source of morbidity and mortality in the NHS, affecting between four to ten percent of inpatients. Up to 80% pressure ulcers are avoidable.

#### Goal

- No avoidable pressure ulcers.

Our definitions of avoidable and unavoidable are as follows:

**Avoidable:** means that the person receiving care developed a pressure ulcer and the provider of care did not do one of the following:

- Evaluate the person's clinical condition and pressure ulcer risk factors
- Plan and implement interventions that are consistent with the person's needs and goals, and recognised standards of practice
- Monitor and evaluate the impact of the interventions

- Revise interventions as appropriate

**Unavoidable:** means that the person receiving care developed a pressure ulcer even though the provider of care had performed all of the elements listed above, or that the person refused to adhere to prevention strategies in spite of education of the consequences of non-adherence.

### Outcome 2010/11 measured Performance

	<b>Achieved 2010/11</b>
Staff are trained and aware of Trust policy on the management of pressure area care	Key clinical staff have attended clinical update training that includes pressure area care. We have developed and launched the 'Skin +' Care Bundle
All patients will be assessed on admission for pressure damage and risk of developing a pressure ulcer	A prevalence audit was undertaken at the start of the year that identified only 1/3 of patients had been assessed on admission. We have identified this as a priority for action and anticipate improvement with the introduction of the new 'Skin +' Care Bundle
Evidence of continuous assessing, planning, implementation and evaluation for avoiding and treating pressure damage during inpatient stay	The audit found that 1/3 of patients' records had documented evidence of regular skin inspections
Avoidable hospital –onset pressure ulcers identified	More work is being undertaken as part of the Countywide Pressure Ulcer Group to develop a reporting and review (root cause analysis) process in order to quantify this

### Action taken to avoid pressure ulcers during 2010/11

- Continued training and awareness
- Skin assessment on admission to hospital
- Testing and roll out of the bundle of care (SKIN+) to support clinical staff to reduce the risk of avoidable pressure damage
- Improved assessment on admission

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## 3.3 Patient Experience

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It is important to the Trust and the staff that each of our patients has the best possible experience whilst in our care, regardless of outcome. Patient experience includes all information shared with

us by patients of their experience with the hospital via feedback methods such as surveys, compliments, complaints, and contacts through our PALS service.

In the period 1 April 10 to end of January 2011 we registered 1376 letters and cards of compliment. We provided over 370 interpreters at a cost of more than £ 27,000  
For the period 1 April 10 to end of February 2011 we registered 243 formal complaints.

### 3.3.1 To implement the Trust's Improving the Patient Experience Strategy

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

#### Goal

- To continue to implement the Trust *Improving the Patient Experience Strategy* and develop an annual improvement plan based on the strategy
- To develop partnerships with patients and patient groups to understand the patient perspective through further development of the patient experience element of quality and through the development of liaison with the newly formed Bedford LINK and Bedfordshire LINK organisations
- To improve our staff's confidence in involving patients and meeting their needs
- To gain feedback from our patients in all forms
- To demonstrate learning from our patients' experiences

#### Outcome 2010/11 measured performance

Patient satisfaction with the care we provide is an extremely important measure of how we are doing. Currently local surveys demonstrate that patients are in the main satisfied with the care we provide, however we continue to be disappointed with results from the National Patient Survey.

	<b>Achieved 2010/11</b>
A Trust forum for the discussion of patient experience is in place.	Our Improving Patient Experience Committee (IPEC) has had eight meetings during the period. Membership includes patient representatives and LINKs members alongside our staff and managers.
Appropriate staff are identified and attend the first phase of the <i>Personal Best</i> <sup>TM</sup> training	The Personal Best training package was delivered and further customer care training is planned
To offer the opportunity to every patient to give feedback on their	We have sought the views and experiences of our patients in a variety of ways;

experience of their care whilst in hospital	<ul style="list-style-type: none"> <li>• A regular patient satisfaction questionnaire survey is distributed to the wards</li> <li>• The catering manager visits the wards and talks to patients about their meals</li> <li>• The ward staff have been asking patients their experience as part of the Productive Ward project</li> <li>• Cancer patients have been asked to participate in surveys</li> <li>• Local surveys have taken place in our outpatients departments</li> <li>• Specialist services have invited their patients to feedback on their experiences</li> </ul>
No mixed sex accommodation	To date the number of sharing events have been very low total number of unjustifiable MSA (mixed sex accommodation) breaches from the start of the reporting period in December 2010 through to 31 <sup>st</sup> March 2011 was 9.
Patients are offered choice of menu for food	The results from our catering survey have shown that at the end of quarter three (December) 72% of patients responded that they were given a menu choice for their meals.
Patients are given sufficient information about their care and treatment	The responses to our local patient satisfaction survey indicate that at up to March 2011, 81.78% of patients considered they had sufficient information.
Patients report that their privacy and dignity is always respected	The average for responses to the question in our local survey up to the end of March 2011 indicated that 95.85% of patients considered their privacy and dignity to be respected.
Improve Performance in “Net promoter question” in CQUINs by achieving more than 82% of patients answering Excellent or Very good in response to the question “Overall how would you rate the quality of your care?”	The average for the responses to the question in our local survey was 81.18% up to the end of March 2011.

### **Action taken to improve our patients’ experience , 2010/11**

- We have delivered a training programme that focussed on the ‘ABC’ of interaction with patients: **A**cknowledging them; **B**eing there for them and **C**oncluding the contact

- Ward sisters have identified a time slot when staff are available for patients and relatives to discuss care issues
- Videos of patient stories are used to train and feedback to staff

### 3.3.2 To improve the patient rating of overall care and experience in the national patient's survey

The National Inpatient Survey is the main source for reporting the experience and views of our patients and is used in the comparative performance tables and as one of the quality indicators called CQUINs.

In 2010/11 our patients participated in the following national surveys:

- Inpatients
- Maternity
- Paediatrics
- Cancer patients

#### Goal

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

#### Outcome measured performance 2010/11

National Survey questions	2008	2009	2010	
Were you involved as much as you wanted to be in decisions about your care and treatment?	52%	42%	53%	↑
Did you find someone on the hospital staff to talk to about your worries and fears?	38%	35%	36%	↑
Were you given enough privacy when discussing your condition and treatment?	70%	66%	70%	↑
Did a member of hospital staff tell you about medication side effects to watch for when you went home?	35%	28%	29%	↑
Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	67%	64%	64%	↔
Overall, how would you rate the care you received?				
• Excellent		30%	36%	↑
• Very Good		43%	40%	↓

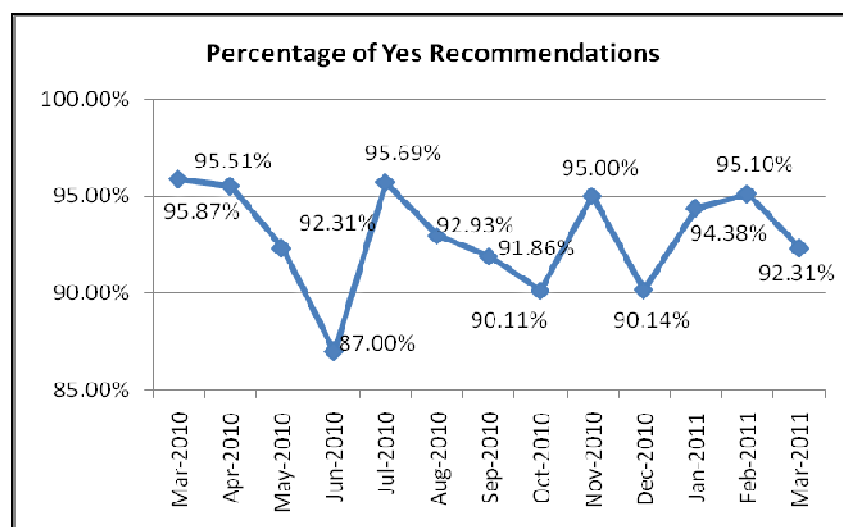
## Local measures

Local Survey questions	Achieved 2010/11
Surveys are structured to ensure national survey questions are included	Our local surveys use the questions from the national survey bank to ensure valid responses. During 2010 we altered our local survey to include the same questions as were being asked in the national survey to enable us to drill down into particular areas and improve.
Patients report they were involved in decisions about their treatment / care	The average for responses received up to the end of March 2011 was 93.52%
Hospital staff were available to talk about patient's worries / concerns	The average for responses received up to the end of March 2011 was 86.37%
Patients report they have enough privacy when discussing condition / treatment	The average for responses received up to the end of March 2011 was 95.86%
Patients are informed about medication side effects	The average for responses received up to the end of March 2011 was 67.06%
Patients are informed about who to contact if they are worried about their condition after leaving hospital	The average for responses received up to the end of March 2011 was 82.19%
Patients report that they would recommend this hospital to their family and friends	The average for responses received up to the end of March 2011 was 92.71%
Patients rate the quality of their care Excellent or Very good	The average for responses received up to the end of March 2011 was 81.18%

## Performance 2010/11

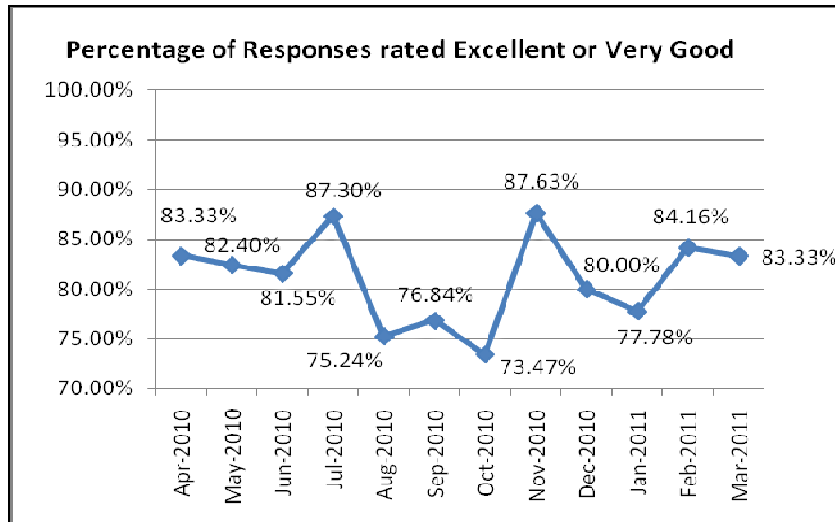
### Would the patient recommend Bedford Hospital to a friend or relative?

(source: Trust Patient Satisfaction survey 2010/11)



## Overall how would you rate the quality of your care?

(source: Trust Patient Satisfaction survey)



### Action taken to improve our patients' experience and the percentage who would recommend us to a relative or friend

- The patient's comments and particular concerns are fed back to the ward and department staff to help their understanding of the patient's perspective and for them to take action
- As part of the Productive ward programme, our wards have started to use posters that say 'You told us....' 'We have responded by .....' to inform our patients and visitors what we are actively doing to improve their stay in hospital
- Improvements to the ward areas have been carried out to increase the space around beds and improve the toilets and shower areas
- Physical improvements have been made to Elizabeth ward and to public toilets

### 3.3.3 To improve the care of the dying patient

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

#### Goals

Allow patients to die in the place of their choice

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

**Outcome: measured Performance 2010/11**

Healthcare workers caring for the dying patient and their relatives / carers are trained in the care of the dying e.g. ACST (Acute Communication Skills Training).  
All appropriate Wards use the Liverpool Care Pathway

LCP documents are completed

Anticipatory prescribing for the key symptoms that may develop in the last days and hours of life is undertaken

To care for dying patients in line with their wishes and needs, the views of bereaved relatives and carers are sought

**Achieved 2010/11**

A cohort of experience nurses have been trained in ACST.  
The LCP is readily available and a training programme is in place

The latest version of the Liverpool Care Pathway (LCP) is in use

Anticipatory prescribing is an integral part of the LCP

How to obtain the views of bereaved relative and carers is under consideration by the End of Life Steering Group

**Action taken to improve the care of the dying patient during 2009/10**

- End of Life steering group was established which developed a work programme with key milestones delivered
- Evidence of achievement of the CQUIN for End of Life has been submitted by Bedford Hospital
- Training in advanced communications has been delivered and will be continued through 2011-12
- Identified senior nursing staff to be ward champions

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### **3.4. Statements from Local Involvement Networks, Overview and Scrutiny Committee and NHS Bedfordshire**

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This Quality Account was forwarded to the following parties for consultation:

- NHS Bedfordshire
- Bedford Borough Overview and Scrutiny Committee  
(Adult Social Care and Health Policy Review and Development Committee)
- Bedford LINK
- Bedfordshire LINK

The responses were considered by the Trust and relevant changes made to the Quality Account action plans. Where an improvement was proposed but not possible in the section looking forward to 2011-12, this will be shared with the stakeholder and a discussion held in relation to how these issues could be addressed in future.



### **Bedford Hospital NHS Trust**

NHS Bedfordshire as the Lead Commissioning PCT for Bedford Hospital NHS Trust has a duty under the National Health Service Act 2006, to confirm that this Quality Account contains accurate and relevant information in relation to the NHS services provided.

NHS Bedfordshire is pleased that Bedford Hospital continues to be registered unconditionally with the Care Quality Commission.

NHS Bedfordshire can confirm that the Quality Account provided for 2010/11 contains accurate information and reflects the quality of current service provision. The account contains the challenges for continued improvement and monitoring of effective patient outcomes which NHS Bedfordshire will continue to review and validate in year.

The trust is to be congratulated for their achievement of healthcare excellence and leadership (HEAL) award for cleanest hospital.

Reasonable steps have been taken to ensure the data has been checked for accuracy against data supplied by the trust throughout the year, regular reviews and monitoring of data is part of the contractual quality monitoring systems.

The Trust has worked hard to improve the quality of services, and the various initiatives that have been introduced to improve the quality of services are encouraging.

The Trust has had regular clinical quality review meetings with the commissioners where progress against an agreed quality schedule is monitored.

The Trust's management of serious incidents has markedly improved with good reporting and management of Serious Incidents (SIs).

The Trust has worked well with partner organisations to improve safeguarding for children and adults in Bedfordshire.

An issue was highlighted for delivering same sex accommodation for all patients; this was resolved by the implementation of single sex endoscopy lists on the 01 April 2011, and will be monitored for effectiveness. It must be noted that all other areas within the trust are compliant and BHT has worked hard to achieve delivering same sex accommodation.

The overall management of infection control at the Trust is good. The Trust managed to reduce infection rates of hospital acquired *C.difficile* and improve compliance with the hand washing amongst staff.

A Joint Working Group between the Trust and other providers in Bedfordshire has been effective with the main aim being to develop an action plan on how to jointly tackle infection control and interface between the community and acute trusts. This has been effective in reducing the number of HCAs.



Angela McNab  
Chief Executive

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## Statement from Bedford Borough Overview and Scrutiny Committee

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### Bedford Borough Council

#### **Adult Social Care and Health PRD Committee: 5 April 2011, extract from the minutes; comment for the Bedford Hospital Quality Account 2011/12**

#### 80. BEDFORD HOSPITAL – QUALITY ACCOUNT 2011/2012

The Committee welcomed Joe Harrison, Chief Executive, Bedford Hospital, and Eiri Jones, Director of Nursing and Patient Services, Bedford Hospital, who attended and presented the draft Quality Account from Bedford Hospital NHS Trust and invited Members to comment on the draft and provide a statement for inclusion in the final published version.

The Director of Nursing provided Members with a summary of the Quality Account highlighting the previous performance in 2010/2011 and the priorities selected for 2011/2012. This year the priorities were:-

#### Patient Safety

- Preventing hospital-acquired infection
- Nutrition
- Documentation

#### Patient experience

- Communication about care
- Staff attitude
- Privacy, dignity and respect

#### Clinical Effectiveness

- The deteriorating patient
- Diabetes
- Dementia Care

Members highlighted previous concerns about two areas that had been considered at previous meetings. The first of those related to outpatients appointments and, in particular, the waiting times in clinics, block bookings and better communication between staff and patients. Joe Harrison acknowledged that the experiences of many outpatients had been and remained far from satisfactory but he assured Members that measures were being taken to improve the situation to avoid delays and where, this was unavoidable, to keep patients better informed. This would be part of the 'patient experience' workstream. One nursing sister at the hospital had responsibility for improving the patient experience and waiting times at outpatient clinics.

The other area of concern related to the lack of a 24 hours thrombolysis service at the Hospital in the light of the need for a stroke patient to have access to thrombolysis where appropriate within a crucial, short period after suffering the stroke. Joe Harrison reminded Members that a full-time service could not be provided at Bedford Hospital as there was only one stroke consultant on staff. However, in conjunction with the Luton and Dunstable Hospital, the level of service being provided was improving and that any stroke patient would receive the necessary treatment well within the critical clinical intervention time required after the onset of a stroke.

The Chair thanked Joe [Chief Executive] and Eiri [Director of Nursing] for their attendance and presentation and for the opportunity for the Committee to comment on the draft Quality Account.

**RESOLVED:**

1. That the Committee supports the priorities for 2011/2012 set out in the Bedford Hospital Quality Account.
2. That Bedford Hospital takes note of the Committee's concerns regarding the experience of patients in outpatient clinics and about access to thrombolysis care.



*Moving towards HealthWatch*

### **BEDFORD HOSPITAL – QUALITY ACCOUNT REPORT 2011**

#### **COMMENTS FROM BEDFORD LINK**

##### **Introduction**

This is a well written and a very good report which clearly identifies future goals. It is good to also see the emphasis on staff training and senior nurse monitoring.

The Glossary is most welcome.

##### **Issues for attention – follows paragraph numbers in draft report document**

###### **Paragraph 2.1.2 – Identified areas for improvement – suggested additions**

- patient meals being served by rotating the order in which they are being served (last is first and the first is last).
- Improved variety of food choice for ethnic patients eg Caribbean
- the link between nutritional needs and the onset of bedsores/pressure ulcers should be highlighted
- water beakers or jugs should be kept topped up at all times

###### **Paragraph 2.1.3 – identified areas for improvement – suggested addition**

- improvement in the way in which discharge planning notes are written so that the notes reflect the patient's personal (at home) situation

###### **Paragraph 2.2.1 – Identified areas for improvement – suggested additions**

- Patients should have access to and be able to input to their care plan and records
- Ward Managers should visit each patient **at least once a day** to keep them informed and listen to any concerns that they may have

### **Paragraph 2.2.1 - New initiatives to be implemented during 2011/12**

Bedford LINK is pleased to see that “reducing pressure ulcers” is an acknowledged issue to be addressed. However in our opinion the following related issue requires further consideration:

- Bedsores/pressure ulcers are often an ongoing issue for patients – where specialised equipment **has** to be used in Hospital, when the patient leaves Hospital this equipment cannot now be hired, so the cost has to either met by the patient or is not available to them – so there is a problem here that needs some attention

### **Paragraph 2.2.2 – Identified areas for improvement**

Bedford LINK would wish to see the following commentary added:

- Nurses to be discouraged from speaking to each other in their own language, especially when dealing directly with patients who are of a different ethnic origin

Bedford LINK would also wish to identify issues that should have immediate attention and are not referred to directly in the QA report.

- Disabled patients need additional care and support when being moved from a chair into bed and vice-versa
- The risk of a fall is often heightened when patients are changed from bedpan toileting to then having to make their way (often unaided) to the toilet cubicle for their particular Ward – additional attention by nursing staff is required in these potentially dangerous situations.

There are also two areas where improved resources could be beneficial to patients:

- Nurses with training and/or with experience in dealing with patients with Multiple Sclerosis
- Nurses with training and/or experience of dealing with Lupus and Sickle Cell illness

### **Paragraph 3.2.1 – To improve care for Stroke patients – Goal**

Bedford LINK is aware of the report prepared by the Care Quality Commission in 2010 **Supporting Life After Stroke – Local Assessment Report – Bedfordshire PCT Area**. The overall conclusion of this report was that Bedfordshire was amongst the “least well performing”. Whilst the “Management of Transfer Home” achieved Level 4 (out of 10), “Early Supported Discharge” achieved Level 1. It is recognised

that Bedford Hospital is not responsible for all of the factors in this low performance, but with its colleague organisations within Bedfordshire NHS/PCT it is important that the Hospital continues to ensure that a proper level of continuity of care exists for Stroke patients. This should be added as a **Goal** for 2011/12.

### **Paragraph 3.3.2 – National Patients Survey**

The results of this are noted. It is pleasing to see that improvements are now being shown for 2010, but it appears that there is still room for considerable improvement in some aspects of the services which Bedford Hospital provides. Bedford LINK would wish to offer, where it is practicable to support the Hospital to improve its services.

#### **Additional Comments**

##### **1 Pharmacy Services**

This does not appear to be identified specifically, but does contribute to the treatment of hospital patients and in turn their overall wellbeing and satisfaction at how they are dealt with by the Hospital.

Bedford LINK is aware that the length of time that patients have to wait for prescriptions from the Hospital Pharmacy can run into several hours. It is understood that this is caused by the delay in when Junior Doctors “write up” up their Patient Notes – this can be often late into the afternoon, when the patient may have been “signed off” several hours earlier.

This should be added as a key improvement for the Hospital to aim at in 2011/12. An improvement in this particular area will have a beneficial knock – on to a number of the other targets which the Hospital is trying to improve upon.

##### **2 Dignity in Care Charter**

In 2010 the Social Care Institute for Excellence (SCIE) published the **Dignity in Care Charter**.

The Minister for Care Services (Phil Hope) has commended this by indicating that *“Being treated with dignity and respect is the right of every human being. I want to make it the core principle of care.”*

The eight principles of this Charter are as follows:

- Choice and Control
- Communication
- Eating and Nutritional Care
- Pain Management
- Personal Hygiene
- Practical assistance

- Privacy
- Social Inclusion

Each principle has a set of qualitative standards to support it.

Bedford LINK would like to see Bedford Hospital embrace the values contained in this Charter by the inclusion of a statement to that effect in the QA Report.

### **Summary Statement**

Bedford Link values the opportunity to support the Bedford Hospital Trust in its ongoing quest to improve services to patients. It is hoped that our role is viewed by the Trust as a "critical friend" that can be relied on at all times to provide informed advice and support.

Thank you

Arthur Dennis

Bedford LINK Chairman

Laurie Hum

Bedford LINK Co-ordinator

**20 April 2010**

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## Statement from Bedfordshire LINK

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### **COMMENTS FROM BEDFORDSHIRE LINK: Bedford Hospital Quality Accounts 2010-11**

Bedfordshire LINK has commented on the Hospital's Quality Accounts, and the main areas highlighted by the membership on what would make the patient journey safer and more satisfactory is given on page 4 under Priorities for Improvement.



It is difficult to comment on the full document, as we are only knowledgeable in aspects of the patients experience and take the information as written at face value. It is a good report and gives the impression of a well run hospital, although we received the document as a “draft for consultation” and there were gaps on some pages for example data was not available on page 20. Some information is to be re-drafted and there was a section on Accident & Emergency Services over Christmas which had not been inserted because an action plan is being agreed.

We feel that the Hospital is working with us in striving to better the patient experience.

**Bedfordshire LINK**  
**20 April 2011**

## Appendix 1: Bedford Hospital NHS Trust Services (speciality level)

	Service Description	Outpatients	Day cases	Elective <i>Inpatients</i>	Emergency Admission
180	Accident and Emergency	√	√	√	√
320	Cardiology	√	√	√	√
192	Critical Care Medicine (ITU)			√	√
330	Dermatology	√	√	√	√
	Dexa Scanning	√			
330	Tunable Dye Laser Treatment	√	√	√	
307	Diabetic Medicine	√		√	√
430	Elderly Care	√	√	√	√
302	Endocrinology	√	√	√	√
120	ENT	√	√	√	√
301	Gastroenterology	√	√	√	√
300	General Medicine	√	√	√	√
100	General Surgery	√	√	√	√
103	Breast Surgery	√	√	√	√
106	Upper GI	√	√	√	√
104	Lower GI	√	√	√	√
107	Vascular	√	√	√	√
502	Gynaecology	√	√	√	√
309	Haemophilia	√			
560	Midwifery	√	√	√	
370	Medical Oncology	√	√	√	√
361	Nephrology	√	*	*	*
400	Neurology	√	*	*	*
422	Neonatal	√	√	√	√
501	Obstetrics	√	√	√	√
901	Occupational Medicine	√			
130	Ophthalmology	√	√	*	*
140	Oral Maxillo Facial (144)	√	√	*	*
143	Orthodontics	√	√	√	√
420	Paediatrics	√	√	√	√
190	Pain Management	√	√	√	√
160	Plastic Surgery	√	√	√	√

997	Podiatry (Chiropody)	√			
	Radiology	√			√
410	Rheumatology	√	√	√	√
340	Thoracic Medicine	√			
360	Genito-Urinary Medicine/Sexual Health	√	√	√	√
110	Trauma & Orthopaedics	√	√	√	√
101	Urology	√	√	√	√
820	General Pathology	√	√	√	√
821	Blood Transfusion		√		
822	Chemical Pathology				
823	Haematology	√			
824	Histopathology				
830	Immunopathology				
831	Microbiology				
810	Radiology (incs MRI/CT Ultrasound)	√			
	Sub-specialities				
	Audiology	√			
	Dietetics	√			
	Occupational Therapy	√			
	Orthotics	√			
	Orthoptics (130)	√			
	Respiratory	√			
	Retinopathy Screening	√			
	Service Departments				
	Pharmacy	√			
	Physiotherapy	√			
	Speech Therapy	√			
	Theatres				
	Acute Admissions Unit	√	√	√	√

\* Indicates a service provided by another NHS organisation

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

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## Appendix 2: Glossary

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<b>Adverse event</b>	An event that is not anticipated or not known to be related to the person's condition or the intervention being used. Adverse events include near misses
<b>Care Bundle</b>	An evidence based and coordinated approach to care delivery which reduces variation in care.
<b><i>Clostridium difficile</i></b>	<i>Clostridium difficile</i> ( <i>C. difficile</i> ) is a bacterium (germ). It lives harmlessly in the gut of many people. Infection with <i>Clostridium difficile</i> most commonly occurs in people who have recently had a course of antibiotics and are in hospital. Symptoms can range from mild diarrhoea to a life-threatening inflammation of the bowel. No treatment may be needed in mild cases except drinking plenty of fluids. However, treatment with specific antibiotics is needed in more severe cases.
<b>Complaint</b>	An expression of dissatisfaction with something. This can relate to any aspect of a person's care, treatment or support and can be expressed orally or in writing.
<b>CQUIN</b>	Commissioning for Quality and Innovation (CQUIN) payment framework The CQUIN payment framework makes a proportion of providers' income conditional on quality and innovation. Its aim is to support the vision set out in <i>High Quality Care for All</i> of an NHS where quality is the organising principle. The framework was launched in April 2009 and helps ensure quality is part of the commissioner-provider discussion everywhere.
<b>Discharge</b>	The point at which a patient leaves hospital to return home or be transferred to another service, or formal conclusion of a service provided to a person who uses the service
<b>End of life</b>	The last phase of a person's life, when a judgement has been made by an appropriately qualified person that the person has an advanced, progressive, incurable illness, or

that the person's death is imminent.

**End of life care**

The care, treatment and support that is provided to enable a person with advanced, progressive, incurable illness to live as well as possible before they die. End of life care also covers the management of pain and other symptoms, and the provision of psychological, social, spiritual and practical support, and support for the family into bereavement.

**Global Trigger Tool (GTT)**

A systematic process to review patients notes to check for safety and quality of care.

**High Impact Action**

The Chief Nursing Officer for England's programme to improve the quality of care across 10 areas.

**Hypoglycaemia**

a condition that occurs when your blood sugar (glucose) is too low.

**MRSA**

Methicillin Resistant *Staphylococcus Aureus*: There are many strains of this bacterium, but it is a generic term used for any strain of *S. aureus* that is resistant to one or more conventional antibiotics.

MRSA is one example of the *Staphylococcus* family of common bacteria. Many people naturally carry it on their throat, nose and skin, and it can cause a mild infection such as pimples and impetigo in a healthy patient. Occasionally, *Staphylococcus* can get through the skin and cause serious infection elsewhere in the body such as sepsis (blood infection), pneumonia and endocarditis.

**MSSA**

New reporting requirement: MSSA bacteraemia. From January 1<sup>st</sup> this year, it is a mandatory requirement to report methicillin-sensitive *Staphylococcus aureus* (MSSA) to the Health Protection Agency (HPA) in the same way as we do MRSA bacteraemias. Voluntary national surveillance data indicate that the numbers of MSSA bacteraemia are higher than they were ten years ago. The Department of Health (DH) has made this surveillance mandatory in order to establish the extent of which these are healthcare-associated. The DH states, "The availability of a robust and accurate picture of the scale of MSSA infections, nationally and locally, will also support patients in making meaningful choices about their

healthcare” (Department of Health, 2011). They further state that further direction will be published in due course regarding the frequency of publication of these data. There is no reduction target associated with this at present.

**NICE**

National Institute for Health and Clinical Excellence.

NICE is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health.

**NPSA**

National Patient Safety Agency.

The NPSA is an Arm’s Length body of the Department of Health which leads and contributes to improved, safe patient care by informing, supporting and influencing organisations and people working in the health sector.

**PAR team**

Patient At Risk team who are called to intervene and provide specialist care for patients with a high PAR score.

A PAR early warning score is calculated based on the patient’s observations.

**Pressure ulcers**

Pressure ulcers are also known as pressure sores, or bed sores. They occur when the skin and underlying tissue becomes damaged. In very serious cases, the underlying muscle and bone can also be damaged.

People who are unable to move some or all of their body due to illness, paralysis or advanced age often develop pressure ulcers.

**QIPP**

Quality, Innovation, Productivity and Prevention. This is a national programme of change and improvement.

**Risk-adjusted mortality rate**

Hospital mortality rates refer to the percent of patients who die while in a hospital. To calculate observed or raw mortality rates you divide the number of deaths among hospital patients with a specific medical condition or procedure by the total number of patients admitted for that same medical condition or procedure. However, because every patient admitted to the hospital for a given condition does not have the same risk of death,

observed mortality rates aren't a perfect means of comparing the quality of care delivered by different hospitals. For example, it would be surprising if an otherwise healthy 60-year-old patient died following a hip replacement surgery. In contrast, it would be less surprising if a 93-year-old patient with multiple health problems died following that same surgery.

Risk-adjustment is a method used to account for the impact of individual risk factors — such as age, severity of illness(es), and other medical problems — that can put some patients at greater risk for death than others.

**SBAR**

A systematic communication tool which can be used by all grades of clinical staff to ensure effective sharing of concerns about a patient's condition.

**SHA**

Strategic Health Authority  
(Bedford Hospital NHS Trust is within the East of England Strategic Health Authority)

**Stroke**

A stroke is a brain injury caused by sudden interruption of blood flow. A stroke is what happens when the blood supply to part of the brain is cut off. Blood carries essential nutrients and oxygen to the brain. Without a blood supply, brain cells can be damaged or destroyed and won't be able to do their job.

**Venous Thromboembolism**

A venous thromboembolism is a blood clot that forms in a vein. Venous thromboembolism is the one of the commonest cause of avoidable death in our hospitals